wisconsin Medicaid update
and BadgerCare
January 2007 ● No. 2007-09
Wisconsin Medicaid and BadgerCare Information for Providers

To:

- Counties Certified for Outpatient Mental Health/ Substance Abuse Services in the Home or Community
- County Mental Health Coordinators
- Federally Qualified Health Centers
- Master's-Level Psychotherapists
- Mental Health/ Substance Abuse Clinics
- Outpatient Hospital Providers
- Psychiatrists
- Psychologists
- Tribal Human Service Facilitators
- HMOs and Other Managed Care Programs

Outpatient Mental Health Benefit

This *Wisconsin Medicaid and BadgerCare Update* consolidates all of the information for the outpatient mental health benefit which includes the following three services:

- Outpatient mental health services (Evaluation, psychotherapy, and pharmacologic management).
- Central nervous system assessments/tests.
- Health and behavior assessments/ interventions.

Providers should use this *Update* in conjunction with the General Information section of the Mental Health and Substance Abuse Services Handbook and the All-Provider Handbook.

This *Update* includes revised prior authorization forms effective for prior authorizations received after March 1, 2007.

This *Wisconsin Medicaid and BadgerCare Update* consolidates all of the information for the outpatient mental health benefit. This *Update* replaces the following outpatient mental health benefit publications:

- The February 2006 *Update* (2006-15), titled "Wisconsin Medicaid Covers Health and Behavior Assessment and Intervention Services."
- The April 2004 *Update* (2004-34), titled "Medical Record Documentation Requirements for Mental Health and Substance Abuse Services."
- The July 2003 *Update* (2003-60), titled "Changes to local codes, paper claims, and prior authorization for outpatient mental health and substance abuse services as a result of HIPAA."
- The July 1998 *Update* (98-23), titled "Procedure Codes for Billing Central Nervous System Assessments/Tests."
- Outpatient mental health services information in the Wisconsin Medical Assistance Program Provider Handbook, Part H, Divisions I and II.

Providers should use this *Update* in conjunction with the General Information section of the Mental Health and Substance Abuse Services Handbook and the All-Provider Handbook. For substance abuse services, refer to the January 2007 *Update* (2007-08), titled "Outpatient Substance Abuse Treatment Services."

Inside This Update:

New Information

New procedure codes and forms, revised prior authorization forms, and allowable *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code ranges are listed in the Attachments of this *Update*.

Revised Prior Authorization Forms

Revised prior authorization forms include the following:

- Prior Authorization/Psychotherapy Attachment (PA/PSYA), HCF 11031 (01/07).
- Prior Authorization/Mental Health and/or Substance Abuse Evaluation Attachment (PA/EA), HCF 11033 (01/07).

New Optional Form

Wisconsin Medicaid has issued a new optional form that providers may begin using immediately as the recipient's treatment/recovery plan when requesting prior authorization, titled Outpatient Mental Health Assessment and Treatment/Recovery Plan, HCF 11103 (01/07).

Prior authorizations received by Wisconsin Medicaid after March 1, 2007, must include the revised PA/PSYA and an assessment and treatment/recovery plan or the Outpatient Mental Health Assessment and Treatment/Recovery Plan.

More detailed information about forms and codes are included later in this *Update*.

Certification

To be reimbursed for outpatient mental health services, a provider is first required to be certified by the Office of the Secretary of the Department of Health and Family Services (DHFS), Office of Quality Assurance (OQA) for outpatient mental health treatment under HFS 61.91-61.98, Wis. Admin. Code. For information regarding this certification, providers may contact the DHFS, OQA by telephone at (608) 243-2025 or by mail at the following address:

Office of the Secretary of the
Department of Health and Family Services
Office of Quality Assurance
Program Certification Unit
2917 International Ln Ste 300
Madison WI 53704

A provider meeting DHFS, OQA certification should do the following to obtain Medicaid certification.

Agencies should complete the Wisconsin Medicaid Mental Health/Substance Abuse Agency Certification Packet. Refer to Attachment 1 for Medicaid certification requirements and the types of provider numbers assigned for agencies providing the services under the outpatient mental health benefit.

Individual providers should complete the Wisconsin Medicaid Mental Health/Substance Abuse Individual Packet. Refer to Attachment 2 for Medicaid certification requirements and the types of provider numbers assigned for individuals providing services under the outpatient mental health benefit. Individual outpatient mental health benefit providers working in certified clinics must obtain and maintain individual Medicaid certification.

Providers may initiate Medicaid certification for the outpatient mental health benefit by doing one of the following:

- Downloading the mental health and substance abuse certification materials from the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*.
- Calling Provider Services at (800) 947-9627 or (608) 221-9883.

Individual outpatient mental health benefit providers working in certified clinics must obtain and maintain individual Medicaid certification.

- Writing to the following address:
  Wisconsin Medicaid
  Provider Maintenance
  6406 Bridge Rd
  Madison WI 53784-0006

Refer to the General Information section of the Mental Health and Substance Abuse Services Handbook for more information about provider certification, provider numbers, and provider responsibilities.

Covered Services

A strength-based assessment, including a differential diagnostic evaluation, is performed by a Medicaid-certified psychotherapy provider.

Outpatient Mental Health Services

Outpatient mental health services include strength-based assessments (including differential diagnostic evaluations), psychotherapy services, and other psychiatric services (e.g., pharmacologic management, electroconvulsive therapy) in the following settings:

- Office of a provider.
- Hospital.
- Nursing home.
- School.
- Hospital outpatient clinic.
- Outpatient clinic.

Strength-Based Assessments — A strength-based assessment, including a differential diagnostic evaluation, is performed by a Medicaid-certified psychotherapy provider. A physician's prescription is not necessary to perform the assessment. Assessing and recovery/ treatment planning is an ongoing process in collaboration between the provider and recipient.

The strength-based assessment must include:

- The recipient's presenting problem.
- Diagnosis established from the current *Diagnostic and Statistical Manual of Mental Disorders* including all five axes or, for children up to age four, the current *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*.
- The recipient's symptoms that support the given diagnosis.
- The recipient's strengths including current and past biopsychosocial data.
- The recipient's unique perspective and own words about how he or she views his or her recovery, experience, challenges, strengths, needs, recovery goals, priorities, preferences, values, and lifestyle of the recipient, areas of functional impairment, family and community support, and needs.
- Barriers and strengths to the recipient's progress and independent functioning.
- Necessary consultation to clarify the diagnosis and treatment.

Refer to Attachment 16 for allowable procedure codes and modifiers for strength-based assessments.

Psychotherapy and Treatment/Recovery Planning — Psychotherapy services include strategies to reduce the severity and distress of persistent symptoms, promote personal insight, assist in coping with symptoms, and identify supports that are effective. In addition, services may include individual and family psychoeducation to help the individual and family members develop coping skills for handling problems posed by mental illness in a family member.

The goals of psychotherapy and specific objectives to meet those goals must be

documented in the recipient's treatment/recovery plan that is based on the strength-based assessment. The treatment/recovery plan includes documentation of the signs of improved functioning that will be used to measure progress toward specific objectives at identified intervals as agreed upon by the provider and recipient. A mental health diagnosis and medications for mental health issues used by the recipient must be documented in the treatment/recovery plan.

Wisconsin Medicaid covers most of the psychiatry services described in *Current Procedural Terminology* (CPT). Refer to Attachment 16 for a complete list of CPT codes reimbursed by Wisconsin Medicaid. Attachment 16 includes allowable procedure codes and modifiers for psychotherapy and treatment/recovery planning.

Central Nervous System Assessments/Tests

Central nervous system assessments/tests include the following:

- Psychological testing.
- Assessment of aphasia.
- Developmental testing, limited and extended.
- Neurobehavioral status exams.
- Neuropsychological testing.

Specific services include assessments and tests, with interpretations and reports. Wisconsin Medicaid covers all of the Central Nervous System Assessments/Tests described in CPT. Refer to Attachment 16 for allowable procedure codes and modifiers.

Health and Behavior Assessment and Intervention Services

Health and behavioral assessment and intervention services are those offered to patients who present with primary physical illnesses, diagnoses, or symptoms and may benefit from assessments and interventions that focus on the biopsychosocial factors related to the patient's health status. These services do not represent preventive medicine counseling and risk factor reduction interventions.

Wisconsin Medicaid covers all of the health and behavioral assessment and intervention services described in CPT. Refer to Attachment 16 for allowable procedure codes and modifiers.

Wisconsin Medicaid covers all of the health and behavioral assessment and intervention services described in CPT.

Special Circumstances

The following are requirements for covered services:

- A signed and dated physician's prescription/order is required for Medicaid coverage of all services provided under the outpatient mental health benefit except central nervous system assessments/tests, differential diagnostic evaluations, and health and behavior assessments.
- For psychotherapy, the provider is required to engage in face-to-face contact with the recipient for at least 5/6 of the time.

Policies regarding concurrent coverage of services are as follows:

- Wisconsin Medicaid covers a continuum of non-inpatient hospital substance abuse and mental health services, including day treatment and psychotherapy.
- Medicaid covers outpatient substance abuse services concurrently with outpatient mental health and/or adult mental health day treatment services as long as both services are medically

necessary and appropriate. Refer to the "Prior Authorization" section of this *Update* for additional information on concurrent services.

Services Provided via Telehealth

Providers certified under HFS 61.91-61.98, Wis. Admin. Code, may provide most services described under the outpatient mental health benefit via Telehealth. Telehealth services provided by psychiatrists and Ph.D. psychologists in private practice are also reimbursed.

Providers certified under HFS 61.91-61.98, Wis. Admin. Code, may provide most services described under the outpatient mental health benefit via Telehealth.

In addition, effective for DOS on and after July 1, 2006, Wisconsin Medicaid reimburses the originating site a facility fee. These recent changes to Telehealth policy came after the General Information section of the Mental Health and Substance Abuse Services Handbook was published. The general section of the handbook contains information about Telehealth requirements and claims submission. Refer to the June 2006 Update (2006-58) titled, "Wisconsin Medicaid Reimburses Selected Services Provided Through Telemedicine," for updated Telehealth policy information.

Noncovered Services

The following services are not covered by Wisconsin Medicaid:

- Collateral interviews with persons not stipulated in HFS 104.13(2)(c)1, Wis. Admin. Code, and consultations, except as provided in HFS 107.06(4)(d), Wis. Admin. Code.
- Psychotherapy for persons with the primary diagnosis of mental retardation, except when they experience psychological problems that necessitate psychotherapeutic intervention.
- Psychotherapy provided in a person's home.
- Self-referrals. "Self-referral" means that a provider refers a recipient either to an agency in which the provider has a direct financial interest or to himself or herself acting as a practitioner in private practice.
- Court appearances except when necessary to defend against commitment.

Note: For more information on noncovered services, see HFS 107.03, Wis. Admin. Code.

Documentation Requirements

Wisconsin Medicaid reimburses the provision of services. Documenting the services provided is part of the provision of services.

Refer to Attachment 3 for documentation requirements for all mental health and substance abuse service providers, including outpatient mental health providers. For additional information regarding documentation requirements, refer to the General Information section of the Mental Health and Substance Abuse Services Handbook.

Prior Authorization

Outpatient Mental Health Services

Prior authorization (PA) requirements are as follows:

- *Pharmacologic Management and Electroconvulsive Therapy* — There is no PA requirement for pharmacologic management or electroconvulsive therapy.
- *Differential Diagnostic Evaluation and Psychotherapy:*
  - ✓ *Differential Diagnostic Evaluation* — Differential diagnostic evaluation services up to six hours in a two-year calendar period may be provided without PA. Services in excess of six hours in a two-year calendar period accumulate toward the 15-hour/ $500 PA threshold. Providers need to

use procedure code H0046 for these excess hours.

- ✓ *Psychotherapy* — Psychotherapy services and any substance abuse services under 15 hours or $500, whichever is reached first, per recipient, per calendar year may be provided without PA.

Prior authorization is required for outpatient mental health services beyond 15 hours or $500 *of combined outpatient mental health and substance abuse services only,* whichever limit is reached first, in a calendar year. This 15-hour/$500 accumulation requirement is exclusive of the health and behavioral intervention PA threshold and any other PA threshold as stated in HFS 104.01(12)(a)1.j, Wis. Admin. Code. Prior authorization is required beyond $500 in a calendar year for mental health and/or substance abuse services provided in an outpatient hospital.

Central Nervous System Assessments/ Tests

There is no PA requirement for central nervous system assessments/tests. Central nervous system testing may be part of the mental health evaluation, but it does not require PA and must be billed under the appropriate codes.

Health and Behavior Assessments/ Interventions

Prior authorization requirements are as follows:

- *Health and Behavior Assessments* — There is no PA requirement for health and behavior assessments.
- *Health and Behavior Interventions* — Health and behavior intervention services under 15 hours or $500, per recipient, per calendar year, whichever is reached first, may be provided without PA.

  Prior authorization is required for health and behavior intervention services beyond 15 hours or $500 *of these services only,* whichever limit is reached first, in a calendar year. This 15-hour/$500 accumulation requirement is exclusive of the outpatient mental health and substance abuse PA threshold and all other thresholds as stated in HFS 104.01(12)(a)1.j, Wis. Admin. Code. Prior authorization is required beyond $500 in a calendar year for health and behavior intervention services provided in an outpatient hospital.

Prior Authorization and Concurrent Mental Health Services

Prior authorization requirements for mental health services are as follows:

- *Concurrent Outpatient Substance Abuse and Psychotherapy Services* — Requests for psychotherapy concurrent with substance abuse therapy may be approved when the PA requests indicate both providers are aware of the service being provided by the other therapist and there is a description of how services are being coordinated. The overall intensity of service must be within the range ordinarily approved for outpatient mental health or substance abuse services (e.g., intensive substance abuse outpatient treatment is not generally approved concurrently with one to two hours of family psychotherapy per week, but one two-hour substance abuse group therapy session plus one one-hour individual psychotherapy session may be approved.)
- *Concurrent Outpatient Psychotherapy Services and Adult Mental Health Day Treatment* — Outpatient psychotherapy services provided concurrently with adult mental health day treatment services that are in excess of the 15-hour/$500 requirement may be prior authorized when the provider

Requests for psychotherapy concurrent with substance abuse therapy may be approved when the PA requests indicate both providers are aware of the service being provided by the other therapist and there is a description of how services are being coordinated.

demonstrates all three of the following conditions:

- ✓ Both services are diagnostically appropriate for the recipient.
- ✓ The providers are communicating with each other and the recipient about the recipient's needs, the treatment is coordinated, and the outpatient services augment the day treatment services.
- ✓ One of the following statements is true:
  - There is a pre-existing relationship between the recipient and the outpatient provider.
  - The recipient has appropriate day treatment needs, and the recipient has a need for specialized intervention that the day treatment staff is not trained to provide.
  - The recipient is transitioning from day treatment to outpatient services.

- *Concurrent Psychotherapy Services Involving More Than One Provider* — Multiple psychotherapy, defined as two or more providers simultaneously seeing one recipient for the same service, is generally not reimbursable by Wisconsin Medicaid, unless there is substantial documentation supporting the medical necessity for this.

Reimbursement for Prior Authorized Services

Wisconsin Medicaid does not reimburse providers for services provided either before the grant date or after the expiration date indicated on the approved Prior Authorization Request Form (PA/RF), HCF 11018 (Rev. 10/03). If the provider delivers a service either before the grant date or after the expiration date of an approved PA request or provides a service that requires PA without obtaining PA, the provider is responsible for the cost of the service. In these situations, providers may *not* collect payment from the recipient.

Wisconsin Medicaid does not reimburse providers for services provided either before the grant date or after the expiration date indicated on the approved Prior Authorization Request Form (PA/RF), HCF 11018 (Rev. 10/03).

Prior authorization does not guarantee reimbursement. To receive Medicaid reimbursement, *all* Medicaid requirements must be met. For more information about general PA requirements, obtaining PA forms and attachments, and submitting PA requests, refer to the All-Provider Handbook.

Prior Authorization Request Forms and Attachments

Outpatient Mental Health Services

To request PA for outpatient mental health services, providers are required to submit the following completed forms and required documentation to Wisconsin Medicaid:

- Prior Authorization Request Form. The completion instructions and samples of the PA/RF are located in Attachments 4, 5, and 6.
- Prior Authorization/Psychotherapy Attachment (PA/PSYA), HCF 11031 (01/07). The completion instructions and PA/PSYA are located in Attachments 7 and 8.

  Providers must use the revised PA/PSYA for PAs received by Wisconsin Medicaid after March 1, 2007.
- The recipient's assessment and treatment/recovery plan. It must include all the elements listed in Attachment 9.

  Providers may submit the same information on a new optional form, the Outpatient Mental Health Assessment and Treatment/Recovery Plan, HCF 11103 (01/07). The completion instructions and Outpatient Mental Health Assessment and Treatment/Recovery Plan are located in Attachments 10 and 11 for photocopying and may also

be downloaded and printed from the Medicaid Web site.

Prior authorizations received by Wisconsin Medicaid after March 1, 2007, must include the revised PA/PSYA and an assessment and treatment/recovery plan or the Outpatient Mental Health Assessment and Treatment/Recovery Plan.

- If the PA requests a differential diagnostic evaluation in excess of the PA threshold hours, submit the PA with the Prior Authorization/Mental Health and/or Substance Abuse Evaluation Attachment (PA/EA), HCF 11033 (01/07). The completion instructions and PA/EA are located in Attachments 12 and 13 for photocopying and may also be downloaded and printed from the Medicaid Web site.

  Providers must use the revised PA/EA for PAs received by Wisconsin Medicaid after March 1, 2007.

Providers may submit selected medical documentation with a PA request and indicate the intended use in lieu of writing the same requested information on the PA attachment. For example, a copy of a recent assessment may be attached.

Health and Behavior Interventions

To request PA for health and behavior interventions, providers are required to submit the following completed forms and required documentation to Wisconsin Medicaid:

- Prior Authorization Request Form. Refer to Attachments 4, 5, and 6 for PA/RF completion instructions and sample forms for outpatient mental health services.
- Prior Authorization/Health and Behavior Intervention Attachment (PA/HBA), HCF 11088 (Rev. 06/05). The completion instructions and PA/HBA are located in Attachments 14 and 15.

Providers may submit selected medical documentation with a PA request and indicate the intended use in lieu of writing the same requested information on the PA attachment. For example, a copy of a recent assessment may be attached.

Grant and Expiration Dates

Refer to the Prior Authorization section of the All-Provider Handbook for information on other circumstances affecting PA, such as determination of grant dates and service interruptions.

Refer to the General Information section of the Mental Health and Substance Abuse Services Handbook for backdating procedures.

Claims Submission

Coordination of Benefits

Except for a few instances, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. Therefore, the provider is required to make a reasonable effort to exhaust all existing other health insurance sources before submitting claims to Wisconsin Medicaid or to state-contracted HMOs.

Except for a few instances, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service.

Refer to the Coordination of Benefits section of the All-Provider Handbook for more information about services that require other health insurance billing, exceptions, claims submission procedures for recipients with other health insurance, and the Other Coverage Discrepancy Report, HCF 1159 (Rev. 08/05).

Diagnosis Codes (Submitted on the CMS 1500 and UB-92 Claim Forms)

All diagnoses must be from the ICD-9-CM coding structure and must be allowed for the

date of service (DOS). Claims received without an allowable ICD-9-CM code are denied.

Refer to Attachment 16 for a list of allowable diagnosis code ranges for the outpatient mental health benefit.

Procedure Codes (Submitted on the CMS 1500 Claim Form)

Healthcare Common Procedure Coding System (HCPCS) codes are required on all outpatient mental health claims. Claims or adjustments received without a HCPCS code are denied. Refer to Attachment 16 for allowable procedure codes and modifiers. Refer to Attachment 17 for maximum allowable fees and copayment rates.

Providers are encouraged to submit claims electronically, since electronic claims submission usually reduces claim errors.

For procedure codes that do not indicate a time increment, providers are required to use the rounding guidelines in Attachment 18.

Revenue Codes (Submitted on the UB-92 Claim Form)

Refer to Attachment 16 or the National UB-92 Uniform Billing Manual for a list of allowable revenue codes for the outpatient mental health benefit for services provided by outpatient mental health clinics. However, outpatient mental health services, other than group therapy and medication management (which are not separately billable for inpatient hospital recipients), provided by a psychiatrist or psychologist to a hospital inpatient recipient must be billed on the CMS 1500 claim form.

Place of Service Codes (Submitted on the CMS 1500 Claim Form)

Allowable place of service codes for the outpatient mental health benefit are included in Attachment 16.

The outpatient mental health benefit does not include services provided in the home or community settings. For outpatient services covered in the home or community, refer to the July 2006 Update (2006-56), titled "Outpatient Mental Health Services in the Home and Community for Adults," about outpatient mental health and substance abuse services in the home and community.

Electronic Claims Submission

Providers are encouraged to submit claims electronically, since electronic claims submission usually reduces claim errors. Claims for services provided under the outpatient mental health benefit may be submitted using the 837 Health Care Claim: Professional or the 837 Health Care Claim: Institutional transaction. Electronic claims may be submitted *except* when Wisconsin Medicaid instructs the provider to submit additional documentation with the claim. In these situations, providers are required to submit paper claims.

Refer to the Informational Resources section of the All-Provider Handbook for more information about electronic transactions.

Paper Claims Submission

With the exception of services provided under the outpatient mental health benefit billed as hospital outpatient services using revenue codes, paper claims for mental health services must be submitted using the CMS 1500 claim form. Refer to Attachment 19 for CMS 1500 claim form instructions. Attachments 20, 21, and 22 are samples of outpatient mental health benefit claims.

Paper claims for services provided under the outpatient mental health benefit billed as hospital outpatient services using appropriate revenue codes must be submitted using the UB-92 claim form. Refer to Attachment 23 for UB-92 claim form instructions. Attachment 24 is a sample of an outpatient mental health benefit claim. Wisconsin Medicaid does not provide the CMS 1500 or the UB-92 claim forms. These forms

may be obtained from any federal forms supplier.

Reimbursement

Wisconsin Medicaid reimburses outpatient mental health services for the following professionals in an outpatient mental health clinic:

- Master's level therapist in a certified mental health clinic as required under HFS 61.91-61.98, Wis. Admin. Code.
- Psychiatrist.
- Ph.D. psychologist.
- Ancillary provider.

Psychiatrists and Ph.D. psychologists may also be reimbursed for outpatient psychotherapy services in private practice.

Ancillary Providers

Wisconsin Medicaid reimburses coordination of care services and delegated medical acts (e.g., giving injections or checking medications) provided by ancillary providers (e.g., registered nurses) if all the following are true:

- The services are provided under the *direct, immediate, on-site* supervision of a psychiatrist.
- The services are pursuant to the plan of treatment.
- The supervising psychiatrist has not provided Medicaid-reimbursable services during the same evaluation or psychotherapy visit.

Note: "On-site" means that the supervising psychiatrist is in the same building in which services are being provided and is immediately available for consultation or, in the case of emergencies, for direct intervention. The psychiatrist is not required to be in the same room as the ancillary provider, unless dictated by medical necessity and good medical practice.

Claims for services services provided by ancillary providers must be submitted under the supervising psychiatrist's Medicaid provider number using the appropriate CPT code for the service performed. These services are not to be billed in addition to or combined with the service, if the psychiatrist sees the patient during the same visit.

Reimbursement Limits

Wisconsin Medicaid reimburses outpatient mental health service providers the lesser of the maximum allowable fee or the billed amount for a service. Other reimbursement limits are as follows:

- Pharmacologic Services Limit — A maximum of two units per day and four units per calendar month may be reimbursed by Wisconsin Medicaid.
- Central Nervous Assessments/Tests Limit — A maximum of six hours per DOS, per recipient, may be reimbursed by Wisconsin Medicaid.
- Health and Behavioral Assessments/ Interventions Limit — A maximum of eight units of assessment and/or intervention services combined with intervention services (procedure codes 96150-96155), per recipient, per DOS may be reimbursed by Wisconsin Medicaid.
- Psychotherapy Limit — A maximum of 15 hours or $500, whichever is reached first, per recipient, per calendar year, may be provided without PA.
- Differential Diagnostic Evaluation Limit — Differential diagnostic evaluation services of up to six hours in a two-year period may be provided without PA. Services in excess of six hours in a two-year period may be claimed as exceeded service, which accumulate toward the 15-hour/$500 PA threshold. For more detailed information about differential diagnostic evaluations and PA, refer to Attachment 9.

Claims for services services provided by ancillary providers must be submitted under the supervising psychiatrist's Medicaid provider number using the appropriate CPT code for the service performed.

Recipient Copayment Information

Providers are prohibited from collecting copayment from nursing home residents and individuals under age 18 receiving services under the outpatient mental health benefit. All other recipients receiving services under the outpatient mental health benefit are charged copayments.

Refer to the Recipient Eligibility section of the All-Provider Handbook for general copayment policies, exemptions, and limitations.

Maximum allowable fee schedules list all the procedure codes allowed by Wisconsin Medicaid for various provider types and the maximum allowable fee for each code. The maximum allowable fee amount determines the copayment amount providers may request from a recipient for most services provided under the outpatient mental health benefit. Services greater than 15 hours or $500 of accumulated services per recipient, per calendar year, are exempt from copayment.

Information Regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *dhfs.wisconsin.gov/medicaid/*.

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Attachments

ATTACHMENT 1

Certification Requirements for the Outpatient Mental Health Benefit Provided by Agencies

This attachment outlines Wisconsin Medicaid certification requirements for all Medicaid outpatient mental health benefit providers. Prior to obtaining Wisconsin Medicaid certification, mental health benefit providers are required to be certified by the Office of the Secretary of Health and Family Services (DHFS), Office of Quality Assurance (OQA). County/tribal social or human services agencies that request billing-only status do not need to be certified by the DHFS.

Additional services provided by outpatient mental health benefit providers are italicized in the table. These services are included in the table because they can be provided to recipients by outpatient mental health benefit providers, but the services can also be provided to other target populations by other types of providers.

The following table lists required provider numbers and definitions for agencies providing the outpatient mental health benefit.

Definitions for Provider Numbers	
Type of Provider Number	**Definition**
Billing/Performing Provider Number	Issued to providers to allow them to identify themselves on claims as either the biller of services or the performer of services.
Billing-Only Provider Number	Issued to counties or tribes to allow them to serve as the biller of services when contracting with a service performer.
Group/Clinic Billing Number	Issued only to physicians and Ph.D. psychologists as an accounting convenience for a clinic in which more than one individual provider performs the service(s). A provider using a group/clinic billing number receives one reimbursement, one Remittance and Status Report, and the 835 Health Care Claim Payment/Advice for covered services performed by individual providers within the group/clinic.

The following terms are used in the table:

- "Agency Providing the Service" — The agency whose staff actually performs the service.
- "Agency Only Allowed to Bill for the Service" — The agency that submits claims to Wisconsin Medicaid for the service. This agency does not perform the service but contracts with a provider to perform the service on the billing agency's behalf. Only a county/tribal social or human services agency can be a billing agency.

Service	Type of Agency	Certification Requirements				Type of Provider Number Assigned
		Office of the Secretary of the Department of Health and Family Services/Office of Quality Assurance	Wisconsin Medicaid	Section of the Certification Packet to Be Completed*	County/Tribal Social or Human Services Agency Required?	
Central Nervous System Assessments/ Tests	Agency Providing the Service	The agency is required to obtain a Wisconsin DHFS certificate to provide outpatient mental health services as authorized under HFS 61.91-61.98, Wis. Admin. Code (which meets Wisconsin Medicaid's HFS 105, Wis. Admin. Code, requirement).	The agency is required to do the following: • Have a DHFS, OQA certificate on file. • Complete and submit a Mental Health/Substance Abuse Agency Certification Packet. An allowable Medicaid performing provider is required to perform the service (psychiatrist or Ph.D. psychologist).	Outpatient Mental Health Services	No	Outpatient mental health clinic billing/performing provider number
	Agency Only Allowed to Bill for the Service	Not required	The agency is required to complete and submit a Mental Health/Substance Abuse Agency Certification Packet to be a billing-only provider for an outpatient mental health clinic. An allowable Medicaid performing provider is required to perform the service (psychiatrist or Ph.D. psychologist).	Outpatient Mental Health Services	Yes	Outpatient mental health clinic billing provider number
Health and Behavior Assessment/ Intervention	Agency Providing the Service	The agency is required to obtain a Wisconsin DHFS certificate to provide outpatient mental health services as authorized under HFS 61.91-61.98, Wis. Admin. Code (which meets Wisconsin Medicaid's HFS 105, Wis. Admin. Code, requirement).	The agency is required to do the following: • Have a DHFS, OQA certificate on file. • Complete and submit a Mental Health/Substance Abuse Agency Certification Packet. An allowable Medicaid performing provider is required to perform the service (Master's level psychotherapist, Ph.D. psychologist, or psychiatrist).	Outpatient Mental Health Services	No	Outpatient mental health facility billing/performing provider number
	Agency Only Allowed to Bill for the Service	Not required	The agency is required to complete and submit a Mental Health/ Substance Abuse Agency Certification Packet to be a billing-only provider for an outpatient mental health clinic. An allowable Medicaid performing provider is required to perform the service.	Outpatient Mental Health Services	Yes	Outpatient mental health facility billing provider number

Service	Type of Agency	Certification Requirements				Type of Provider Number Assigned
		Office of the Secretary of the Department of Health and Family Services/Office of Quality Assurance	Wisconsin Medicaid	Section of the Certification Packet to Be Completed*	County/Tribal Social or Human Services Agency Required?	
Outpatient Mental Health Services	Agency Providing the Service	The agency is required to obtain a Wisconsin Department of Health and Family Services certificate to provide outpatient mental health services as authorized under HFS 61.91-61.98, Wis. Admin. Code (which meets Wisconsin Medicaid's HFS 105, Wis. Admin. Code, requirement).	The agency is required to do the following: • Have a DHFS, OQA certificate on file. • Complete and submit a Mental Health/Substance Abuse Agency Certification Packet. An allowable Medicaid performing provider is required to perform the service.	Outpatient Mental Health Services	No	Outpatient mental health billing/ performing provider number
			Hospitals are required to complete one of the following: • The Hospital Certification Packet if billing as an outpatient hospital (using revenue codes on the UB-92 claim form). Outpatient hospitals utilizing Master's-level therapists are required to be certified as a DHFS/OQA-certified mental health clinic under HFS 61.91-61.98, Wis. Admin. Code. The clinic must be located at the hospital site to bill as an outpatient hospital. • The Mental Health/Substance Abuse Agency Certification Packet if billing as a certified outpatient mental health clinic (using procedure codes on the CMS 1500 claim form).	Outpatient Mental Health Services	No	Hospitals will receive one of the following: • Outpatient mental health clinic billing/performing provider number. • Outpatient hospital number.
	Agency Only Allowed to Bill for the Service	Not required	The agency is required to complete and submit a Mental Health and Substance Abuse Agency Certification Packet to be a billing-only provider for outpatient mental health services. An allowable Medicaid performing provider is required to perform the service.	Outpatient Mental Health Services	Yes	Outpatient mental health clinic billing/ performing provider number

*These are sections of the Medicaid Mental Health/Substance Abuse Agency Certification Packet.

ATTACHMENT 2

Certification Requirements for the Outpatient Mental Health Benefit Provided by Individuals

This attachment outlines Wisconsin Medicaid certification requirements for individuals. The first table identifies the individual provider types who may perform the Medicaid outpatient mental health benefit. The second table includes definitions for provider numbers, and the third table lists individual providers, prerequisites, and Medicaid certification requirements.

The list of allowable provider types includes psychiatrists and Ph.D. psychologists who perform in private practice. These providers may submit claims as well as perform the services. Psychiatrists and Ph.D. psychologists may also work within certified programs as defined in this attachment.

Allowable Individual Providers for the Outpatient Mental Health Benefit	
Central Nervous System Assessments/Tests	Ph.D. Psychologist
	Psychiatrist
	Pediatrician
	Neurologist
Health and Behavior Assessment/Intervention	Master's-Level Psychotherapist
	Ph.D. Psychologist
	Psychiatrist
Outpatient Mental Health Services	Master's-Level Psychotherapist
	Ph.D. Psychologist
	Psychiatrist

Definitions for Provider Numbers	
Type of Provider Number	**Definition**
Billing/Performing Provider Number	Issued to providers to allow them to identify themselves on claims as either the biller of services or the performer of services.
Nonbilling Performing Provider Number	Issued to providers who practice under the professional supervision of another provider or in collaboration with other providers. This provider number may not be used to independently submit claims to Wisconsin Medicaid.

Individual Providers, Prerequisites, and Medicaid Certification Requirements			
Type of Provider	**Prerequisite**	**Medicaid Certification Requirements**	**Type of Provider Number Assigned**
Master's-Level Psychotherapist	The provider is required to do the following: • Work in a certified mental health clinic as required under HFS 61.91-61.98, Wis. Admin. Code (which meets Wisconsin Medicaid's HFS 105, Wis. Admin. Code, requirement). • Have a clinical social worker's license, a marriage and family therapist's license, or a professional counselor's license from the Department of Regulation and Licensing **or** a Provider Status Approval Letter issued by the Office of the Secretary of the Department of Health and Family Services, Office of Quality Assurance.	The provider is required to complete and submit a Mental Health and Substance Abuse Individual Packet.	Nonbilling performing provider number
Psychiatrist	The provider is required to do the following: • Have a license to practice as a physician, according to ch. 448.05 and 448.07, Wis. Stats. (which meets Wisconsin Medicaid's HFS 105, Wis. Admin. Code, requirement). • Have proof that he or she completed psychiatric residency.	The provider is required to complete and submit a Physician/Osteopath/ Physician Assistant Certification Packet.	Billing/performing provider number
Pediatrician	The provider is required to have a license to practice as a physician, according to ch. 448.05 and 448.07, Wis. Stats. (which meets Wisconsin Medicaid's HFS 105, Wis. Admin. Code, requirement).	The provider is required to complete and submit a Physician/Osteopath/ Physician Assistant Certification Packet.	Billing/performing provider number
Neurologist	The provider is required to have a license to practice as a physician, according to ch. 448.05 and 448.07, Wis. Stats. (which meets Wisconsin Medicaid's HFS 105, Wis. Admin. Code, requirement).	The provider is required to complete and submit a Physician/Osteopath/ Physician Assistant Certification Packet.	Billing/performing provider number
Ph.D. Psychologist	The provider is required to have a license to practice as a psychologist, according to ch. 455, Wis. Stats. This must be at the independent practice level. If the effective date of the license is prior to October 1, 1991, the provider is required to have one of the following: • A copy of his or her listing in the current National Register of Health Service Providers in Psychology (as required under HFS 105.22[1][b], Wis. Admin. Code). • A copy of documentation that shows he or she is eligible to be listed in the National Register of Health Service Providers in Psychology. The provider is required to include documentation of a doctorate that meets the National Register/Association of State and Provincial Psychology Boards' "Guidelines for Defining a Doctoral Degree in Psychology" with at least two years (minimum of 3,000 hours) of supervised experience in health service. One year (1,500 hours) must be post-internship, which meets the National Register's "Guidelines for Defining an Internship or Organized Health Service Training Program" (as required under HFS 105.22[1][b], Wis. Admin. Code).	The provider is required to complete and submit a Mental Health and Substance Abuse Individual Packet.	Billing/performing provider number

ATTACHMENT 3
Mental Health and Substance Abuse Services Documentation Requirements

Providers are responsible for meeting Medicaid's medical and financial documentation requirements. Refer to HFS 106.02(9)(a), Wis. Admin. Code, for preparation and maintenance documentation requirements and HFS 106.02(9)(c), Wis. Admin. Code, for financial record documentation requirements.

The following are Wisconsin Medicaid's medical record documentation requirements (HFS 106.02[9][b], Wis. Admin. Code) as they apply to all mental health and substance abuse services. In each element, the applicable administrative code language is in parentheses. The provider is required to include the following written documentation in the recipient's medical record, as applicable:

1. Date, department or office of the provider (as applicable), and provider name and profession.
2. Presenting problem (chief medical complaint or purpose of the service or services).
3. Assessments (clinical findings, studies ordered, or diagnosis or medical impression).
   a. Intake note signed by the therapist (clinical findings).
   b. Information about past treatment, such as where it occurred, for how long, and by whom (clinical findings).
   c. Mental status exam, including mood and affect, thought processes — principally orientation X3, dangerousness to others and self, and behavioral and motor observations. Other information that may be essential depending on presenting symptoms includes thought processes other than orientation X3, attitude, judgment, memory, speech, thought content, perception, intellectual functioning, and general appearance (clinical findings and/or diagnosis or medical impression).
   d. Biopsychosocial history, which may include, depending on the situation, educational or vocational history, developmental history, medical history, significant past events, religious history, substance abuse history, past mental health treatment, criminal and legal history, significant past relationships and prominent influences, behavioral history, financial history, and overall life adjustment (clinical findings).
   e. Psychological, neuropsychological, functional, cognitive, behavioral, and/or developmental testing as indicated (studies ordered).
   f. Current status, including mental status, current living arrangements and social relationships, support system, current activities of daily living, current and recent substance abuse usage, current personal strengths, current vocational and educational status, and current religious attendance (clinical findings).
4. Treatment plans, including treatment goals, which are expressed in behavioral terms that provide measurable indices of performance, planned intervention, mechanics of intervention (frequency, duration, responsible party[ies]) (disposition, recommendations, and instructions given to the recipient, including any prescriptions and plans of care or treatment provided).
5. Progress notes (therapies or other treatments administered) must provide data relative to accomplishment of the treatment goals in measurable terms. Progress notes also must document significant events that are related to the person's treatment plan and assessments and that contribute to an overall understanding of the person's ongoing level and quality of functioning.

ATTACHMENT 4
Prior Authorization Request Form (PA/RF) Completion Instructions for Outpatient Mental Health Services

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information will include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. The Prior Authorization Request Form (PA/RF), HCF 11018, is used by Wisconsin Medicaid and is mandatory when requesting PA. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Providers may submit PA requests, along with all applicable service-specific attachments, including the Prior Authorization/Psychotherapy Attachment (PA/PSYA), HCF 11031, or the Prior Authorization/Mental Health and/or Substance Abuse Evaluation Attachment (PA/EA), HCF 11033, by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — Name and Address — Billing Provider

Enter the name and complete address (street, city, state, and zip code) of the billing provider. The name listed in this element must correspond with the Medicaid provider number listed in Element 4. *No other information should be entered in this element, since it also serves as a return mailing label*. Nonbilling performing providers (Master's-level psychotherapists) are required to indicate the clinic name and number as the billing provider.

Element 2 — Telephone Number — Billing Provider

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider. Nonbilling performing providers (Master's-level psychotherapists) must indicate the clinic telephone number.

Element 3 — Processing Type

The processing type is a three-digit code used to identify a category of service requested. Enter processing type "126" for psychotherapy.

Element 4 — Billing Provider's Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must match the provider name listed in Element 1. Nonbilling performing providers (Master's degree psychotherapists) are required to indicate the eight-digit Medicaid provider number of the clinic.

SECTION II — RECIPIENT INFORMATION

Element 5 — Recipient Medicaid ID Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient's Medicaid identification card or the Medicaid Eligibility Verification System (EVS) to obtain the correct identification number.

Element 6 — Date of Birth — Recipient

Enter the recipient's date of birth in MM/DD/YY format (e.g., September 8, 1966, would be 09/08/66).

Element 7 — Address — Recipient

Enter the complete address of the recipient's place of residence, including the street, city, state, and zip code. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 8 — Name — Recipient

Enter the recipient's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 9 — Sex — Recipient

Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 10 — Diagnosis — Primary Code and Description

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested. A diagnosis code is not required on PA requests for psychiatric evaluation or diagnostic tests.

Element 11 — Start Date — SOI (not required)

Element 12 — First Date of Treatment — SOI (not required)

Element 13 — Diagnosis — Secondary Code and Description

Enter the appropriate secondary ICD-9-CM diagnosis code and description additionally descriptive of the recipient's clinical condition. A diagnosis code is not required on PA requests for psychiatric evaluation or diagnostic tests.

Element 14 — Requested Start Date

Enter the requested start date for service(s) in MM/DD/YY format, if a specific start date is requested. If backdating is desired, please follow the procedure for requesting it described in the All-Provider Handbook.

Element 15 — Performing Provider Number

Enter the eight-digit Medicaid provider number of the provider who actually performs the service. Enter this number only if it is different from the billing provider number listed in Element 4.

Element 16 — Procedure Code

Enter the appropriate *Current Procedural Terminology* code or Healthcare Common Procedure Coding System code for each service/procedure/item requested.

Element 17 — Modifiers

Enter the modifier(s) corresponding to the procedure code listed if a modifier is required by Wisconsin Medicaid.

Element 18 — POS

Enter the appropriate place of service (POS) code designating where the requested service/procedure/item would be provided/performed/dispensed. Refer to Attachment 16 of this *Wisconsin Medicaid and BadgerCare Update* for a list of allowable POS codes.

Element 19 — Description of Service

Enter a written description corresponding to the appropriate procedure code for each service/procedure/item requested.

Element 20 — QR

Enter the appropriate quantity (e.g., number of services, days' supply) requested for the procedure code listed. Refer to Attachment 18 for rounding guidelines.

Element 21 — Charge

Enter the provider's usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to the provider *Terms of Reimbursement* issued by the Department of Health and Family Services.

Element 22 — Total Charges

Enter the anticipated total charge for this request.

Element 23 — Signature — Requesting Provider

The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 24 — Date Signed

Enter the month, day, and year the PA/RF was signed (in MM/DD/YY format).

Do not enter any information below the signature of the requesting provider — this space is reserved for Wisconsin Medicaid consultants and analysts.

ATTACHMENT 5
Sample Prior Authorization Request Form (PA/RF) for Psychotherapy Services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 10/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616, or providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
		1234567

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number — Billing Provider	3. Processing Type
I.M. Provider **1 W. Williams** **Anytown, WI 55555**	**(XXX) XXX-XXXX**	**126**
	4. Billing Provider's Medicaid Provider Number **87654321**	

SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number	6. Date of Birth — Recipient (MM/DD/YY)	7. Address — Recipient (Street, City, State, Zip Code)
1234567890	**MM/DD/YY**	**1234 Street St.** **Anytown, WI 55555**
8. Name — Recipient (Last, First, Middle Initial) **Recipient, Ima A.**	9. Sex — Recipient ❑ M ☒ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
296.3 Major depressive disorder		
13. Diagnosis — Secondary Code and Description	14. Requested Start Date	
309.0 Adjustment reaction	**MM/DD/YY**	

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
98765432*	**90806**	**HP**				**11**	**Individual psychotherapy**	**6**	**XXX.XX**
98765432*	**90847**	**HP**				**11**	**Family psychotherapy**	**13**	**XXX.XX**

**Note:* Only private clinics are required to indicate a performing provider number.

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

22. **Total Charges** **XXX.XX**

23. **SIGNATURE** — Requesting Provider	24. Date Signed
I.M. Provider	**MM/DD/YY**

FOR MEDICAID USE

Procedure(s) Authorized:

Quantity Authorized:

❑ Approved

Grant Date _____ Expiration Date _____

❑ Modified — Reason:

❑ Denied — Reason:

❑ Returned — Reason:

SIGNATURE — Consultant / Analyst _____ Date Signed _____

ATTACHMENT 6
Sample Prior Authorization Request Form (PA/RF) for Evaluation Services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 10/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616, or providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
		1234567

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number — Billing Provider	3. Processing Type
I.M. Provider **1 W. Williams** **Anytown, WI 55555**	**(XXX) XXX-XXXX**	**126**
	4. Billing Provider's Medicaid Provider Number **87654321**	

SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number	6. Date of Birth — Recipient (MM/DD/YY)	7. Address — Recipient (Street, City, State, Zip Code)
1234567890	**MM/DD/YY**	**1234 Street St.** **Anytown, WI 55555**
8. Name — Recipient (Last, First, Middle Initial) **Recipient, Ima A.**	9. Sex — Recipient ❑ M ☒ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description	11. Start Date — SOI	12. First Date of Treatment — SOI
13. Diagnosis — Secondary Code and Description	14. Requested Start Date **MM/DD/YY**	

15. Performing Provider Number	16. Procedure Code	17. Modifiers 1	2	3	4	18. POS	19. Description of Service	20. QR	21. Charge
98765432	**90801**	**HP**				**11**	**Psych diag. interview examination**	**2**	**XXX.XX**

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

22. **Total Charges** **XXX.XX**

23. **SIGNATURE** — Requesting Provider	24. Date Signed
I.M. Provider	**MM/DD/YY**

FOR MEDICAID USE

Procedure(s) Authorized:

Quantity Authorized:

❑ Approved

Grant Date _____ Expiration Date _____

❑ Modified — Reason:

❑ Denied — Reason:

❑ Returned — Reason:

SIGNATURE — Consultant / Analyst _____ Date Signed _____

ATTACHMENT 7
Prior Authorization/Psychotherapy Attachment (PA/PSYA) Completion Instructions

(A copy of the "Prior Authorization/Psychotherapy Attachment [PA/PSYA] Completion Instructions" is located on the following pages.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11031A (Rev. 01/07)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PSYCHOTHERAPY ATTACHMENT (PA/PSYA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The Prior Authorization/Psychotherapy Attachment (PA/PSYA), HCF 11031, must be submitted as the request for outpatient mental health services. Use of the accompanying Outpatient Mental Health Assessment and Treatment/Recovery Plan form, HCF 11103, is voluntary; providers may develop their own forms as long as they include all of the information and are formatted exactly as this form.

Attach the completed PA/PSYA, the Outpatient Mental Health Assessment and Treatment/Recovery Plan form (or its equivalent), and physician prescription (if necessary) to the Prior Authorization Request Form (PA/RF), HCF 11018, and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to the following address:

Wisconsin Medicaid
Prior Authorization
Suite 88
6406 Bridge Road
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

GENERAL INSTRUCTIONS

The information contained in the PA/PSYA is used to make a decision about the amount and type of psychotherapy that is approved for Wisconsin Medicaid reimbursement. Thoroughly complete each section and include any material that would be helpful to understand the necessity of the services being requested. Where noted in these instructions, material from personal records may be substituted for the information requested on the form. *Indicate on the PA/PSYA the intended use of the attached materials.*

Prior authorization for psychotherapy is not granted when another provider already has an approved PA for psychotherapy services for the same recipient. In these cases, Wisconsin Medicaid recommends that the recipient request that previous providers notify Wisconsin Medicaid that they have discontinued treatment with this recipient. The recipient may also submit a signed statement of his or her desire to change providers and include the date of the change. The new provider's PA may not overlap with the previous provider's PA.

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Medicaid Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth — Recipient
Enter the date of birth of the recipient (in MM/DD/YY format).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Performing Provider
Enter the name of the therapist who will be providing treatment.

Element 5 — Performing Provider's Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the performing provider.

Element 6 — Telephone Number — Performing Provider
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the performing provider.

Element 7 — Discipline — Performing Provider
Enter the discipline (credentials) of the therapist who will be providing treatment. The discipline should correspond with the name listed in Element 4.

SECTION III — SERVICE REQUEST

Based on the information recorded on the Outpatient Mental Health Assessment and Treatment/Recovery Plan, the following services are requested.

Element 8 — Number of Minutes Per Session
Indicate the length of session for each format listed.

Element 9 — Frequency of Requested Sessions
Enter the anticipated frequency of requested sessions. If requesting sessions more frequently than once per week, please describe why they are needed. If a series of treatments that are not regular is anticipated (e.g., frequent sessions for a few weeks, with treatment tapering off thereafter), indicate the total number of hours of treatment requested, the time period over which the treatment is requested, and the expected pattern of treatment.

Element 10 — Total Number of Sessions / Hours Requested for This PA Period
Indicate the total hours of treatment requested for this PA period, based on the information entered in Elements 19 and 20, and the duration of this request. (Services at intensities lower than an average of one hour weekly may be approved for up to six months' duration.) *This quantity should match the quantity(ies) in Element 20 of the PA/RF.*

Element 11 — Treatment Approach
Indicate the type of treatment utilized. The treatment approach utilized must be consistent with the diagnosis and symptoms, and its effectiveness must be supported by research.

Element 12 — Estimated Termination Date
Indicate the estimated date for meeting long-term treatment goals.

Element 13 — Signature — Performing Provider
Enter the signature of the performing provider.

Element 14 — Date Performing Provider Signed the Form
Enter the month, day, and year the PA/PSYA was signed (in MM/DD/YYYY format).

ATTACHMENT 8
Prior Authorization/Psychotherapy Attachment (PA/PSYA) (for photocopying)

(A copy of the "Prior Authorization/Psychotherapy Attachment [PA/PSYA]" is located on the following pages.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11031 (Rev. 01/07)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PSYCHOTHERAPY ATTACHMENT (PA / PSYA)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Psychotherapy Attachment (PA/PSYA) Completion Instructions, HCF 11031A. Failure to provide all elements with intended use clearly indicated could result in return or denial of PA request. Attach a copy of the recipient's assessment and treatment/recovery plan. Providers may submit the same information on a new optional form, the Outpatient Mental Health Assessment and Treatment/Recovery Plan, HCF 11103.

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Date of Birth — Recipient	3. Recipient Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name — Performing Provider	5. Performing Provider's Medicaid Provider Number
6. Telephone Number — Performing Provider	7. Discipline — Performing Provider

SECTION III — SERVICE REQUEST

Based on the information recorded on the Department of Health and Family Services Outpatient Mental Health Assessment and Treatment/Recovery Plan, the following services are requested.

8. Number of Minutes Per Session

   Individual _____ Group _____ Family _____ Other _____

9. Frequency of Requested Sessions (Services in excess of once weekly require specific justification.)

   Monthly _____ Twice/month _____ Once/week _____ Other _____

10. Total Number of Sessions / Hours Requested for This PA Period.

11. Treatment Approach

12. Estimated Termination Date

13. **SIGNATURE** — Performing Provider	14. Date Signed

ATTACHMENT 9
Elements and Documentation Requirements for Strength-Based Assessment and Recovery/Treatment Planning

Strength-Based Assessment

The assessment shall include:

- The recipient's presenting problem.
- Diagnosis established from the current *Diagnostic and Statistical Manual of Mental Disorders* including all five axes or, for children up to age four, the current *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*.
- The recipient's symptoms that support the given diagnosis.
- The recipient's strengths including current and past biopsychosocial data.
- The recipient's unique perspective and own words about how he or she views his or her recovery, experience, challenges, strengths, needs, recovery goals, priorities, preferences, values and lifestyle, areas of functional impairment, family and community support, and needs.
- Barriers and strengths to the recipient's progress and independent functioning.
- Necessary consultation to clarify the diagnosis and treatment.

Documentation

Document the assessment of the recipient, basing it on the recipient's strengths. Include current as well as historical biopsychosocial data. Include mental status, developmental, school/vocational, cultural, social, spiritual, medical, past and current traumas, substance use/dependence and outcome of treatment, and past mental health treatment/outcome. Include the recipient's view of the issues; for a child, give the parent/primary caregiver's view. An assessment dated within three months of the request may be attached.

Treatment/Recovery Plan

The goals of psychotherapy and specific objectives to meet those goals shall be documented in the recipient's treatment/recovery plan that is based on the strength-based assessment. In the treatment/recovery plan, the signs of improved functioning that will be used to measure progress toward specific objectives at identified intervals, agreed upon by the provider and recipient shall be documented. A mental health diagnosis and medications for mental health issues used by the recipient shall be documented in the treatment/recovery plan.

ATTACHMENT 10
Outpatient Mental Health Assessment and Treatment/ Recovery Plan Completion Instructions

(A copy of the "Outpatient Mental Health Assessment and Treatment/Recovery Plan Completion Instructions" is located on the following pages.)

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OUTPATIENT MENTAL HEALTH ASSESSMENT AND TREATMENT / RECOVERY PLAN COMPLETION INSTRUCTIONS (Optional Form)

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients. The Outpatient Mental Health Assessment and Treatment/Recovery Plan, HCF 11103, may be used by providers of mental health outpatient services to document their assessment of a client's clinical condition and treatment /recovery plan. This information provides the clinical information required to request prior authorization (PA) for services covered by Wisconsin Medicaid.

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing PA requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

Use of the accompanying Outpatient Mental Health Assessment and Treatment/Recovery Plan is optional and voluntary; providers may use their own format for assessments and treatment/recovery plans as long as they include all of the information required and listed in the Outpatient Mental Health Assessment and Treatment/Recovery Plan.

Attach the completed Prior Authorization/Psychotherapy Attachment (PA/PSYA), HCF 11031, the recipient's assessment and treatment/recovery plan, and the physician prescription (if necessary) to the Prior Authorization Request Form (PA/RF), HCF 11018, and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

GENERAL INSTRUCTIONS

Complete Elements 1-7 when submitting the initial PA request and at least once every three years when the performing provider remains unchanged. For continuing PA on the same individual, it is not necessary to rewrite Elements 1-7; corrections/updates on information in Elements 1-7 should be made in Elements 8 through 10. When Elements 1-7 are not rewritten, submit a copy of what had previously been written, along with updated information in the remaining elements of the Outpatient Mental Health Assessment and Treatment/Recovery Plan. Medical consultants reviewing the PA requests have a file containing the previous requests, but they base their decisions on the clinical information submitted, so it is important to present all current, relevant clinical information.

SECTION I — INITIAL ASSESSMENT / REASSESSMENT

Include the date of the initial assessment / reassessment. Complete this section at least every three years.

Element 1 — Presenting Problem
Enter the consumer's presenting problem.

Element 2 — Initial Assessment.
Enter the date of the five-axis *Diagnostic and Statistical Manual of Mental Disorders* (DSM) or *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0-3) diagnosis.

Element 3 — Symptoms
Enter the symptoms presented by the consumer that were used to formulate the diagnoses given in Element 1. Assess the severity of the symptoms and indicate them as mild, moderate, or severe.

Element 4 — Strength-Based Assessment
Document the assessment of the consumer, basing it on the consumer's strengths. Include current as well as historical biopsychosocial data. Include mental status, developmental, school/vocational, cultural, social, spiritual, medical, past and current traumas, substance use/dependence and outcome of treatment, and past mental health treatments and outcomes. Include the consumer's view of the issues. For a child, give the parent/primary caregiver's view of the issues. The provider may attach an assessment dated within three months of the request.

Element 5 —
Indicate the family/community support for this consumer. Indicate other services the consumer is receiving or to which he or she has been referred.

Element 6 —
Present the strengths that could impact the consumer's progress on goals; address any barriers to the progress.

Element 7 — Consultation
Indicate whether or not there has been a consultation to clarify the diagnosis and/or treatment and, if so, the credentials of the consultant. Indicate the date of the most recent consultation. Briefly describe the results of the consultation or attach a copy of the report, if available.

SECTION II — SUBSEQUENT ASSESSMENTS

Not required when Initial Assessment section is completed. This section must be completed for subsequent reviews.

Element 8 —
Indicate any changes in Elements 1-7, including the current Global Assessment of Functioning, change in diagnoses (five axes), and supporting symptoms.

Element 9 — Current Symptoms
Indicate the symptoms currently being exhibited by the consumer.

SECTION III — TREATMENT/RECOVERY PLAN

Element 10 —
Goals are general and answer the question, "What do the consumer and yourself, as therapist, want to accomplish in treatment?" Objectives are specific and answer the question, "What steps will the consumer and yourself, as therapist, be taking in therapy to help meet the stated goals?"

Indicate the goals of the consumer's treatment (short term for this PA period and long term for the next year).

For each objective, indicate the treatment modality (individual [I]; group [G]; family [F]; other [O] — please specify) being implemented during this PA period. In the first column, indicate the behaviors you and the consumer have agreed upon as signs of improved functioning. In the second column, describe the progress, or lack thereof, in the behaviors identified in the first column since the last review. *Client report alone is not an observable sign*. In the third column, indicate changes in goals/objectives in the treatment/recovery plan.

Element 11 —
Indicate how the consumer's strengths are being utilized in meeting the goals of the treatment/recovery plan. If little or no progress is reported, discuss why you believe further treatment is needed for this consumer and how you plan to address the need for continued treatment. Discuss your plans for assisting the consumer in meeting his or her goals. If progress is reported, give rationale for continued services.

Element 12 —
Indicate whether the consumer is on any psychoactive medication and the date of the most recent medication check. List psychoactive medications and target symptoms for each medication.

SECTION IV — SIGNATURES

Element 13 — Signature — Performing Provider

Element 14 — Date Signed

Element 15 — Signature* — Consumer / Legal Guardian

Element 16 — Date Signed

* The outpatient psychotherapy clinic certification standards requiring the consumer to approve and sign the treatment plan and agree with the clinician on a course of treatment (HFS 36.16[3], Wis. Admin. Code) will be met if this form is signed by the consumer or a legal guardian for children.

ATTACHMENT 11
Outpatient Mental Health Assessment and Treatment/ Recovery Plan (for photocopying)

(A copy of the optional “Outpatient Mental Health Assessment and Treatment/Recovery Plan” is located on the following pages.)

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DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11103 (01/07)

OUTPATIENT MENTAL HEALTH ASSESSMENT AND TREATMENT / RECOVERY PLAN (Optional)

The use of this form is voluntary and optional and may be used in place of the consumer's assessment and treatment/recovery plan.

SECTION I — INITIAL ASSESSMENT / REASSESSMENT

Date of initial assessment / reassessment _____

1. Presenting Problem

2. Diagnosis (Use current *Diagnostic and Statistical Manual of Mental Disorders* (DSM) / *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC: 0-3) code and description:

   Axis I

   Axis II

   Axis III

   Axis IV List psychosocial/environment problems

   Axis V Current Global Assessment of Functioning (GAF)

3. Symptoms — List consumer's symptoms in support of given DSM/DC:0-3 diagnoses.

   Severity of Symptoms ❑ Mild ❑ Moderate ❑ Severe

4. Strength-Based Assessment (include current and historical biopsychosocial data and how these factors will affect treatment. Also include mental status, developmental and intellectual functioning, school / vocational, cultural, social, spiritual, medical, past and current traumas, substance use/dependence and outcome of treatment, and past mental health treatments, and outcomes.)

5. Describe the consumer's unique perspective and own words about how he or she views his or her recovery, experience, challenges, strengths, needs, recovery goals, priorities, preferences, values and lifestyle of the consumer, areas of functional impairment, family and community support, and needs.

6. What do you anticipate as barriers / strengths toward progress and independent functioning?

SECTION I — INITIAL ASSESSMENT / REASSESSMENT (Continued)

7. Has there been a consultation to clarify diagnosis / treatment? ❑ Yes ❑ No
   If so, by whom?
   ❑ Psychiatrist ❑ Ph.D. Psychologist ❑ Master's-Level Psychotherapist ❑ Other (Specify) _____
   ❑ Advanced Practice Nurse Prescriber-Psych/Mental Health Specialty
   ❑ Substance Abuse Counselor
   Date of latest consultation _____
   Results of consultation or attach report, if available.

SECTION II — SUBSEQUENT ASSESSMENTS

Not required when Initial Assessment section is completed. This section must be completed for subsequent reviews.

8. Indicate any changes in Elements 1-7, including the current GAF, change in diagnoses (five axes), and symptoms in support of new diagnosis, including mental status.

9. Describe current symptoms/problems.

❑ Anxiousness	❑ Homicidal	❑ Oppositional	❑ Somatic Complaints
❑ Appetite Disruption	❑ Hopelessness	❑ Panic Attacks	❑ Substance Use
❑ Decreased Energy	❑ Hyperactivity	❑ Paranoia	❑ Suicidal
❑ Delusions	❑ Impaired Concentration	❑ Phobias	❑ Tangential
❑ Depressed Mood	❑ Impaired Memory	❑ Police Contact	❑ Tearful
❑ Disruption of Thoughts	❑ Impulsiveness	❑ Poor Judgment	❑ Violence
❑ Dissociation	❑ Irritability	❑ School / Home / Community Issues	❑ Worthlessness
❑ Elevated Mood	❑ Manic	❑ Self-Injury	
❑ Guilt	❑ Obsessions / Compulsions	❑ Sexual Issues	
❑ Hallucinations	❑ Occupational Problems	❑ Sleeplessness	

❑ Other _____

SECTION III — TREATMENT / RECOVERY PLAN

Based on strength-based assessments.

10. Treatment plan, as agreed upon with consumer.

    Short term (3 months):

    Long term (within the next year):

Specify objectives utilized to meet the goals.
Indicate modality (individual [I], group [G], family [F], other [O]) after each objective.

	What are the therapist / consumer agreed-upon signs of improved functioning. As reported by _____	Describe progress since last review as agreed-upon with consumer, or lack thereof, on each goal. For children, provide caregiver's report.	Changes in goals / objectives.
1			

SECTION III — TREATMENT / RECOVERY PLAN (Continued)

	What are the therapist / consumer agreed-upon signs of improved functioning. As reported by _____	Describe progress since last review as agreed-upon with consumer, or lack thereof, on each goal. For children, provide caregiver's report.	Identify changes in goals / objectives.
2			
3			

11. How are consumer's strengths being utilized?

If little or no progress is reported, discuss why you believe further treatment is needed and how you plan to address the need for continued treatment. What strategies will you as the therapist, use to assist the consumer in meeting his/her goals? If progress is reported, give rationale for continued services.

12. Is consumer taking any psychoactive medication? ❑ Yes ❑ No
Date of last medication check _____

List psychoactive medications and dosages.
Medication and dosages _____ Target symptoms _____
Medication and dosages _____ Target symptoms _____
Medication and dosages _____ Target symptoms _____

Is informed consent current for all medications? ❑ Yes ❑ No

SECTION IV — SIGNATURES

13. **SIGNATURE** — Performing Provider	14. Date Signed
15. **SIGNATURE** — Consumer / Legal Guardian*	16. Date Signed

*The outpatient psychotherapy clinic certification standards requiring the consumer to approve and sign the treatment plan and agree with the clinician on a course of treatment (HFS 36.16[3], Wis. Admin. Code) will be met if this form is signed by the consumer/legal guardian for children.

ATTACHMENT 12
Prior Authorization/Mental Health and/or Substance Abuse Evaluation Attachment (PA/EA) Completion Instructions

(A copy of the "Prior Authorization/Mental Health and/or Substance Abuse Evaluation Attachment [PA/EA] Completion Instructions" is located on the following pages.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11033A (Rev. 01/07)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / MENTAL HEALTH AND / OR SUBSTANCE ABUSE EVALUATION ATTACHMENT (PA/EA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information will include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Providers should refer to their service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization/Mental Health and/or Substance Abuse Evaluation Attachment (PA/EA) to the Prior Authorization Request Form (PA/RF), HCF 11018, and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

GENERAL INSTRUCTIONS

The information contained in the PA/EA is used to make a decision about the amount and type of mental health and substance abuse evaluation that is approved for Wisconsin Medicaid reimbursement. Thoroughly complete each section and include any material that would be helpful to understand the necessity of the services being requested.

GENERAL INFORMATION ABOUT MENTAL HEALTH AND SUBSTANCE ABUSE EVALUATIONS

A mental health and substance abuse (MH/SA) evaluation is an examination of the medical, biopsychosocial, behavioral, developmental, and environmental aspects of the recipient's situation and an assessment of the recipient's immediate and long-range therapeutic needs, developmental priorities, personal strengths and liabilities, and potential resources of the recipient's family and supports. Typically, the provider documents the results by using either the multiaxial system or nonaxial format, as described in the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM) developed by the American Psychiatric Association or the current *Diagnosis Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: 0-3* (DC:0-3) for children up to age 4.

A MH/SA evaluation is performed to serve as a guide to optimal treatment and prediction of outcomes for the patient, including diagnosing a mental disorder. Formulating a diagnosis is only the first step in an evaluation. To develop an adequate treatment plan, the clinician invariably requires considerable additional information about the person being evaluated beyond that required to make a diagnosis. The scope, as well as the medical necessity, of the evaluation is based on the presenting problem/circumstance, including symptoms indicative of a disorder (as defined in the current DSM/DC:0-3) and may include one or more of the following common clinical activities:

- Diagnostic/assessment interviews with the recipient.
- Assessment interviews with the recipient's family and supports.
- Review of history and previous treatment.
- Psychological testing.
- Documenting the results.

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Medicaid Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth — Recipient
Enter the date of birth of the recipient (in MM/DD/YY format).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Performing Provider
Enter the name of the therapist who will be performing the evaluation.

Element 5 — Performing Provider's Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the performing provider.

Element 6 — Telephone Number — Performing Provider
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the performing provider.

Element 7 — Discipline — Performing Provider
Enter the discipline (credentials) of the therapist who will be performing the evaluation. The discipline should correspond with the name listed in Element 4.

SECTION III — DOCUMENTATION

Element 8
Document the type of evaluation being requested and why it is needed. For instance, the evaluation may be a competency examination or it may be necessitated by the need to confirm a diagnosis. If the recipient was referred for evaluation, indicate who made the referral and why. Indicate how the results of the evaluation or testing will be used. Indicate how the recipient will benefit (e.g., indicate if the evaluation might be used to place the recipient in a less restrictive setting or to obtain guardianship that would be in the recipient's best interest). Providers requesting retroactive authorization must document the emergency situation on the count order that justifies such a request and indicate the initial date of service.

Requests for authorization to perform Central Nervous Assessments (CPT procedure codes 96101-96120) should not be included in these requests.

Element 9
Indicate other evaluations the provider is aware of that have been conducted on this recipient in the past two years. Indicate why the requested evaluation does not duplicate earlier evaluations.

A physician's prescription is not required for these evaluation services.

Element 10 — Signature — Performing Provider
Enter the signature of the performing provider.

Element 11 — Date Signed
Enter the month, day, and year the PA/EA was signed (in MM/DD/YYYY format).

ATTACHMENT 13
Prior Authorization/Mental Health and/or Substance Abuse Evaluation Attachment (PA/EA) (for photocopying)

(A copy of the "Prior Authorization/Mental Health and/or Substance Abuse Evaluation Attachment [PA/EA]" is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11033 (Rev. 01/07)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / MENTAL HEALTH AND / OR SUBSTANCE ABUSE EVALUATION ATTACHMENT (PA/EA)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Mental Health and/or Substance Abuse Evaluation Attachment (PA/EA) Completion Instructions, HCF 11033A. Failure to provide all elements with the intended use clearly indicated could result in return or denial of PA requests.

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Date of Birth — Recipient	3. Recipient Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name — Performing Provider	5. Performing Provider's Medicaid Provider Number
6. Telephone Number — Performing Provider	7. Discipline — Performing Provider

SECTION III — DOCUMENTATION

8. Indicate the type of evaluation being requested and why this evaluation is needed. If this was a referral, indicate who made the referral. Be specific as to how the recipient will benefit from this evaluation.

   (Do not include Central Nervous Assessments [CPT procedure codes 96101-96120] in this request.)

9. Indicate other evaluations the provider is aware of that have been conducted on this recipient in the past two years. Indicate why the requested evaluation does not duplicate earlier evaluations.

10. SIGNATURE — Performing Provider	11. Date Signed

ATTACHMENT 14
Prior Authorization/Health and Behavior Intervention Attachment (PA/HBA) Completion Instructions

(A copy of the "Prior Authorization/Health and Behavior Intervention Attachment [PA/HBA] Completion Instructions" is located on the following pages.)

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WISCONSIN MEDICAID
PRIOR AUTHORIZATION / HEALTH AND BEHAVIOR INTERVENTION ATTACHMENT (PA/HBA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Providers should refer to their service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization/Health and Behavior Intervention Attachment (PA/HBA), HCF 11088, to the Prior Authorization Request Form (PA/RF), HCF 11018, and physician prescription and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

INSTRUCTIONS

The information contained in the PA/HBA is used to make a decision about the amount and type of intervention that is approved for Wisconsin Medicaid reimbursement. Thoroughly complete each section and include any material that would be helpful to support the medical necessity of the services being requested. When noted in these instructions, material from personal records may be substituted for the information requested on the form. When substituting material from personal records, indicate the purpose of the materials.

Prior authorization for health and behavior interventions is not granted when another provider already has an approved PA for health and behavior intervention services for the same recipient. In these cases, Wisconsin Medicaid recommends that the recipient request that the other provider notify Wisconsin Medicaid that they have discontinued treatment with this recipient. The recipient may also submit a signed statement of his or her desire to change providers and include the date of the change. The new provider's PA may not overlap with the previous provider's PA.

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Medicaid Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth — Recipient
Enter the date of birth of the recipient (in MM/DD/YY format).

Element 3 — Recipient's Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Performing Provider
Enter the name of the therapist who will be providing the treatment.

Element 5 — Performing Provider's Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the performing provider.

Element 6 — Telephone Number — Performing Provider
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 7 — Credentials — Performing Provider
Enter the credentials of the therapist who will be providing treatment. The discipline should correspond with the name listed in Element 4.

SECTION III — CLINICAL INFORMATION

Element 8 — Physical Health Diagnosis Related to the Need for Health and Behavior Interventions
Enter the physical health diagnosis related to the need for health and behavior intervention services. Indicate the date the diagnosis was given and by whom.

Element 9 — Biopsychosocial Factors Related to the Recipient's Physical Health Status
Enter a summary of the biopsychosocial factors resulting from the recipient's physical health diagnosis as discovered in the health and behavior assessment. Indicate the date of the health and behavior assessment.

Element 10 — Treatment Modalities
Indicate the treatment modalities being implemented.

Element 11 — Treatment Schedule
Enter the anticipated length of sessions, frequency of sessions, and duration of services requested on this PA. If requesting sessions more frequently than once per week, indicate why they are needed. If a series of treatments is anticipated (e.g., frequent sessions for a few weeks, with treatment tapering off thereafter), indicate the total number of hours of treatment requested, the time period over which the treatment is requested, and the expected pattern of treatment. This quantity should match the quantity(ies) in Element 20 of the PA/RF. (Services at intensities lower than the average of one hour weekly may be approved for a duration of up to six months.)

Element 12 — Recipient's Measurable Goals of Treatment Modalities
Indicate the recipient's measurable goals of each treatment modality being requested.

Element 13 — Anticipated Duration of Treatment
Indicate the anticipated duration of treatment to address the issues related to the identified physical health diagnosis listed in Element 8.

Element 14 — Signature — Performing Provider
Enter the signature of the performing provider.

Element 15 — Date Signed
Enter the month, day, and year the PA/HBA was signed (in MM/DD/YYYY format).

.

ATTACHMENT 15
Prior Authorization/Health and Behavior Intervention Attachment (PA/HBA) (for photocopying)

(A copy of the "Prior Authorization/Health and Behavior Intervention Attachment [PA/HBA]" is located on the following page.)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / HEALTH AND BEHAVIOR INTERVENTION ATTACHMENT (PA/HBA)

Providers may submit the completed prior authorization (PA) request by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Health and Behavior Intervention Attachment (PA/HBA) Completion Instructions, HCF 11088A.

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Date of Birth — Recipient	3. Recipient Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name — Performing Provider	5. Performing Provider's Medicaid Provider Number
6. Telephone Number — Performing Provider	7. Credentials — Performing Provider

SECTION III — CLINICAL INFORMATION

8. Physical Health Diagnosis Related to the Need for Health and Behavior Interventions

9. Biopsychosocial Factors Related to the Recipient's Physical Health Status

10. Treatment Modalities

11. Treatment Schedule

12. Recipient's Measurable Goals of Treatment Modalities

13. Anticipated Duration of Treatment

14. **SIGNATURE** — Performing Provider	15. Date Signed

ATTACHMENT 16

Outpatient Mental Health Services Procedure Codes and Revenue Codes

The following tables list the *Current Procedural Terminology* (CPT), Healthcare Common Procedure Coding System, and revenue codes and applicable modifiers that providers are required to use when requesting prior authorization (PA) and submitting claims for outpatient mental health services. Not all providers may be reimbursed for all mental health services. To determine which certified providers may be reimbursed for a particular service, consult the tables in this attachment.

Place of Service Codes (Submitted Only on the CMS 1500 Claim Form)	
03	School (Health and Behavior Assessment and Intervention Services and Outpatient Mental Health Services only)
11[a]	Office
12	Home (Central Nervous System Assessment/Tests only)
21[b]	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room — Hospital
31	Skilled Nursing Facility
32	Nursing Facility
51[b]	Inpatient Psychiatric Facility
54	Intermediate Care Facility/Mentally Retarded
61[b]	Comprehensive Inpatient Rehabilitation Facility
99[c]	Other Place of Service (Outpatient Mental Health Services only)

[a] Services provided in an office setting have to be performed in the office of a Medicaid-certified mental health outpatient clinic.

[b] The POS codes, "21," "51," and "61" are not allowable for Master's-level providers. Payment is included in the hospital's Medicaid diagnosis-related group (DRG) reimbursement.

[c] Only for pharmacologic management in community-based residential facilities.

Professional Level Modifiers (Submitted Only on the CMS 1500 Claim Form)		
Modifier	**Description**	**Providers**
HO	Masters degree level	Master's-level psychotherapist (Master's-level psychotherapists are Master's-level mental health professionals with 3,000 hours of supervised experience or are listed in an appropriate national registry as stated in HFS 61.96, Wis. Admin. Code. This includes registered nurses (RNs) with a Master's degree in psychiatric-mental health nursing or community mental health nursing from a graduate school of nursing accredited by the National League for Nursing.)
HP	Doctoral level	Psychologist, Ph.D.
UA	MD, neurologist, pediatrician, psychiatrist	Psychiatrist billing mental health and substance abuse services Physician billing substance abuse services Physician assistant billing substance abuse services
UB	APNP — psychiatric specialty	Advanced Practice Nurse Prescriber (APNP) — Master's-level RN, only those with an APNP — psychiatric specialty billing pharmacologic management
U8	Physician assistant	Physician assistant billing pharmacologic management

Outpatient Mental Health Services Procedure Codes

(Submitted Only on the CMS 1500 Claim Form)

Psychiatric Diagnostic or Evaluative Interview Procedures

Procedure Code	Description	Certified Providers Who May Perform Service	Modifier (Required)	Limitations	Allowable ICD-9-CM[a] Diagnoses	Allowable Place of Service	Telehealth Services Covered?
90801	Psychiatric diagnostic interview examination (quantity of 1.0 = 1 hour)	Master's degree level Doctoral level Psychiatrist	HO HP UA	Any additional hours beyond six hours of a combination of 90801 and 90802 in a two-year period accumulates toward the PA threshold.[b]	All	03, 11, 21[c], 22, 23, 31, 32, 51[c], 54, 61[c]	Yes (use "GT" modifier)
90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication (quantity of 1.0 = 1 hour)	Master's degree level Doctoral level Psychiatrist	HO HP UA	Any additional hours beyond six hours of a combination of 90801 and 90802 in a two-year period accumulates toward the PA threshold.[b]	All	03, 11, 21[c], 22, 23, 31, 32, 51[c], 54, 61[c]	Yes (use "GT" modifier)
H0046	Mental health services, not otherwise specified (Wisconsin Medicaid: Limitation — Exceeded; Psychotherapy diagnostic interview examination [quantity of 1.0 = 1 hour])	Master's degree level Doctoral level Psychiatrist	HO HP UA	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	All	03, 11, 21[c], 22, 23, 31, 32, 51[c], 54, 61[c]	Yes (use "GT" modifier)

Psychiatric Therapeutic Procedures: Office or Other Outpatient Facility — *Insight Oriented, Behavior Modifying, and/or Supportive Psychotherapy*

Procedure Code	Description	Certified Providers Who May Perform Service	Modifier (Required)	Limitations	Allowable ICD-9-CM* Diagnoses	Allowable Place of Service	Telehealth Services Covered?
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;	Master's degree level Doctoral level Psychiatrist	HO HP UA	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	03, 11, 22, 23	Yes (use "GT" modifier)
90805	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	03, 11, 22, 23	Yes (use "GT" modifier)
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;	Master's degree level Doctoral level Psychiatrist	HO HP UA	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	03, 11, 22, 23	Yes (use "GT" modifier)
90807	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	03, 11, 22, 23	Yes (use "GT" modifier)
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;	Master's degree level Doctoral level Psychiatrist	HO HP UA	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	03, 11, 22, 23	Yes (use "GT" modifier)
90809	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	03, 11, 22, 23	Yes (use "GT" modifier)

[a] ICD-9-CM = *International Classification of Diseases, Ninth Revision, Clinical Modification*.

[b] Diagnostic interview examinations beyond this limit must be billed under H0046, which accumulates toward the 15-hour/$500 calendar year threshold beyond which PA is required.

[c] The POS codes "21," "51," and "61" are not allowable for Master's-level providers. Payment is included in the hospital's Medicaid DRG reimbursement.

Psychiatric Therapeutic Procedures: Office or Other Outpatient Facility — *Interactive Psychotherapy*

Procedure Code	Description	Certified Providers Who May Perform Service	Modifier (Required)	Limitations	Allowable ICD-9-CM[a] Diagnoses	Allowable Place of Service	Telehealth Services Covered?
90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;	Master's degree level	HO	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	03, 11, 22, 23	Yes (use "GT" modifier)
		Doctoral level	HP				
		Psychiatrist	UA				
90811	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	03, 11, 22, 23	Yes (use "GT" modifier)
90812	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;	Master's degree level	HO	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	03, 11, 22, 23	Yes (use "GT" modifier)
		Doctoral level	HP				
		Psychiatrist	UA				
90813	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	03, 11, 22, 23	Yes (use "GT" modifier)
90814	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;	Master's degree level	HO	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	03, 11, 22, 23	Yes (use "GT" modifier)
		Doctoral level	HP				
		Psychiatrist	UA				
90815	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	03, 11, 22, 23	Yes (use "GT" modifier)

[a] ICD-9-CM = *International Classification of Diseases, Ninth Revision, Clinical Modification*.

Psychiatric Therapeutic Procedures: Inpatient Hospital or Residential Care Facility — *Insight Oriented, Behavior Modifying, and/or Supportive Psychotherapy*

Wisconsin Medicaid covers "partial hospital" services under a separate benefit — day treatment/day hospital services (HFS 107.13[4], Wis. Admin. Code).

Procedure Code	Description	Certified Providers Who May Perform Service	Modifier (Required)	Limitations	Allowable ICD-9-CM[a] diagnoses	Allowable Place of Service	Telehealth Services Covered?
90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;	Master's degree level	HO	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	21[b], 31, 32, 51[b], 54, 61[b]	Yes (use "GT" modifier)
		Doctoral level	HP				
		Psychiatrist	UA				
90817	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	21[b], 31, 32, 51[b], 54, 61[b]	Yes (use "GT" modifier)
90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;	Master's degree level	HO	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	21[b], 31, 32, 51[b], 54, 61[b]	Yes (use "GT" modifier)
		Doctoral level	HP				
		Psychiatrist	UA				
90819	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	21[b], 31, 32, 51[b], 54, 61[b]	Yes (use "GT" modifier)
90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;	Master's degree level	HO	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	21[b], 31, 32, 51[b], 54, 61[b]	Yes (use "GT" modifier)
		Doctoral level	HP				
		Psychiatrist	UA				
90822	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	21[b], 31, 32, 51[b], 54, 61[b]	Yes (use "GT" modifier)

[a] ICD-9-CM = *International Classification of Diseases, Ninth Revision, Clinical Modification.*

[b] The POS codes "21," "51," and "61" are not allowable for Master's level providers. Payment is included in the hospital's Medicaid DRG reimbursement.

Psychiatric Therapeutic Procedures: Inpatient Hospital or Residential Care Facility — *Interactive Psychotherapy*

See HFS 107.13, Wis. Admin. Code, for the Medicaid policy on partial hospital/day treatment services. Wisconsin Medicaid covers "partial hospital" services under a separate benefit — day treatment/day hospital services.

Procedure Code	Description	Certified Providers Who May Perform Service	Modifier (Required)	Limitations	Allowable ICD-9-CM[a] diagnoses	Allowable Place of Service	Telehealth Services Covered?
90823	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;	Master's degree level	HO	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	21[b], 31, 32, 51[b], 54, 61[b]	Yes (use "GT" modifier)
		Doctoral level	HP				
		Psychiatrist	UA				
90824	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	21[b], 31, 32, 51[b], 54, 61[b]	Yes (use "GT" modifier)
90826	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;	Master's degree level	HO	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	21[b], 31, 32, 51[b], 54, 61[b]	Yes (use "GT" modifier)
		Doctoral level	HP				
		Psychiatrist	UA				
90827	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	21[b], 31, 32, 51[b], 54, 61[b]	Yes (use "GT" modifier)
90828	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;	Master's degree level	HO	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	21[b], 31, 32, 51[b], 54, 61[b]	Yes (use "GT" modifier)
		Doctoral level	HP				
		Psychiatrist	UA				
90829	with medical evaluation and management services	Psychiatrist	UA	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	21[b], 31, 32, 51[b], 54, 61[b]	Yes (use "GT" modifier)

[a] ICD-9-CM = *International Classification of Diseases, Ninth Revision, Clinical Modification*

[b] The POS codes "21," "51," and "61" are not allowable for Master's level providers. Payment is included in the hospital's Medicaid DRG reimbursement.

Psychiatric Therapeutic Procedures: Other Psychotherapy

Procedure Code	Description	Certified Providers Who May Perform Service	Modifier (Required)	Limitations	Allowable ICD-9-CM[a] Diagnoses	Allowable Place of Service	Telehealth Services Covered?
90845	Psychoanalysis (quantity of 1.0 = 60 minutes)	Master's degree level	HO	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	03, 11, 21[b], 22, 23, 31, 32, 51[b], 54, 61[b]	Yes (use "GT" modifier)
		Doctoral level	HP				
		Psychiatrist	UA				
90846	Family psychotherapy (without the patient present) (quantity of 1.0 = 60 minutes)	Master's degree level	HO	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	03, 11, 21[b], 22, 23, 31, 32, 51[b], 54, 61[b]	Yes (use "GT" modifier)
		Doctoral level	HP				
		Psychiatrist	UA				
90847	Family psychotherapy (conjoint psychotherapy) (with patient present) (quantity of 1.0 = 60 minutes)	Master's degree level	HO	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	03, 11, 21[b], 22, 23, 31, 32, 51[b], 54, 61[b]	Yes (use "GT" modifier)
		Doctoral level	HP				
		Psychiatrist	UA				
90849	Multiple-family group psychotherapy (quantity of 1.0 = 60 minutes)	Master's degree level	HO	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	03, 11, 22, 23, 31, 32, 54	Yes (use "GT" modifier)
		Doctoral level	HP				
		Psychiatrist	UA				
90853	Group psychotherapy (other than of a multiple-family group) (quantity of 1.0 = 60 minutes)	Master's degree level	HO	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	03, 11, 22, 23, 31, 32, 54	No
		Doctoral level	HP				
		Psychiatrist	UA				
90857	Interactive group psychotherapy (quantity of 1.0 = 60 minutes)	Master's degree level	HO	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	03, 11, 22, 23, 31, 32, 54	No
		Doctoral level	HP				
		Psychiatrist	UA				

[a] ICD-9-CM = *International Classification of Diseases, Ninth Revision, Clinical Modification*

[b] The POS codes "21," "51," and "61" are not allowable for Master's level providers. Payment is included in the hospital's Medicaid DRG reimbursement.

Psychiatric Therapeutic Procedures: Other Psychiatric Services or Procedures

Procedure Code	Description	Certified Providers Who May Perform Service	Modifier (Required)	Limitations	Allowable ICD-9-CM[a] Diagnoses	Allowable Place of Service	Telehealth Services Covered?
90862	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy (quantity of 1.0 = 15 minutes)	Master's level psychiatric nurse	HO	Limited to two units per date of service (DOS) and four units per month.[b]	290-298.9, 300.00-316	03, 11, 22, 23, 31, 32, 54, 99	Yes (use "GT" modifier)
		APNP — psychiatric	UB				
		Physician assistant	U8				
		MD, psychiatrist	UA				
90865	Narcosynthesis for psychiatric diagnostic and therapeutic purposes (eg, sodium amobarbital [Amytal] interview) (quantity of 1.0 = 60 minutes)	Doctoral level	HP	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	03, 11, 22, 23, 31, 32, 54	No
		Psychiatrist	UA				
90870	Electroconvulsive therapy (includes necessary monitoring)	Psychiatrist	UA		290-298.9, 300.00-316	03, 11, 21[c], 22, 23, 51[c], 61[c]	No
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes	Master's degree level	HO	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	03, 11, 21[c], 22, 23, 51[c], 61[c]	Yes (use "GT" modifier)
		Doctoral level	HP				
		Psychiatrist	UA				
90876	approximately 45-50 minutes	Master's degree level	HO	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	03, 11, 21[c], 22, 23, 51[c], 61[c]	Yes (use "GT" modifier)
		Doctoral level	HP				
		Psychiatrist	UA				
90880	Hypnotherapy (quantity of 1.0 = 60 minutes)	Master's degree level	HO	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	03, 11, 21[c], 22, 23, 51[c], 61[c]	No
		Doctoral level	HP				
		Psychiatrist	UA				
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient (quantity of 1.0 = 60 minutes)	Master's degree level	HO	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	03, 11, 21[c], 22, 23, 51[c], 61[c]	Yes (use "GT" modifier)
		Doctoral level	HP				
		Psychiatrist	UA				
90899[c,d]	Unlisted psychiatric service or procedure (quantity of 1.0 = 60 minutes)	Master's degree level	HO	Accumulates toward the 15-hour/$500 calendar-year threshold, beyond which PA is required (except for inpatient hospital).	290-298.9, 300.00-316	03, 11, 21[c], 22, 23, 51[c], 61[c]	No
		Doctoral level	HP				
		Psychiatrist	UA				

[a] ICD-9-CM = *International Classification of Diseases, Ninth Revision, Clinical Modification*

[b] This code is to be used by all providers only when greater than 90 minutes of individual psychotherapy is provided on one day. Bill the total time (quantity of 1.0 = 60 minutes). It is not to be used for group psychotherapy. Submit with documentation showing medical necessity.

[c] The POS codes "21," "51," and "61" are not allowable for Master's-level providers. Payment is included in the hospital's Medicaid DRG reimbursement.

[d] Not payable in conjunction with 90804-90819, 90821-90824, 90826-90829, 90845, or 90875-90876 by the same provider on same DOS.

Outpatient Mental Health Services Revenue Codes[a]

(Submitted Only on the UB-92 Claim Form)

Revenue Code	Category	Description	Limitations	Allowable ICD-9-CM Diagnoses[b]	Telehealth Services Covered?
0900	Psychiatric/Psychological Treatments	General Classification	Accumulates toward the $500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	For individual services only.
0902	Psychiatric/Psychological Treatments	Milieu Therapy	Accumulates toward the $500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	For individual services only.
0903	Psychiatric/Psychological Treatments	Play Therapy	Accumulates toward the $500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	For individual services only.
0909	Psychiatric/Psychological Treatments	Other Psychiatric/ Psychological Treatment	Accumulates toward the $500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	For individual services only.
0910	Psychiatric/Psychological Treatments	General Classification	Accumulates toward the $500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	For individual services only.
0911	Psychiatric/Psychological Treatments	Rehabilitation	Accumulates toward the $500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	For individual services only.
0914	Psychiatric/Psychological Treatments	Individual Therapy	Accumulates toward the $500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	For individual services only.
0915	Psychiatric/Psychological Treatments	Group Therapy	Accumulates toward the $500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	For individual services only.
0916	Psychiatric/Psychological Treatments	Family Therapy	Accumulates toward the $500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	For individual services only.
0919	Psychiatric/Psychological Treatments	Other Psychiatric/ Psychological Service	Accumulates toward the $500 calendar-year threshold, beyond which PA is required.	290-298.9, 300.00-316	For individual services only.

[a] Outpatient mental health services, other than group therapy and medication management, provided by a psychiatrist or psychologist to a hospital inpatient recipient, must be billed on the CMS 1500 claim form.

[b] The list of *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis codes for outpatient mental health services is inclusive. However, not all Medicaid-covered outpatient mental health services are appropriate or allowable.

Central Nervous System Assessments/Tests Procedure Codes

(Submitted Only on the CMS 1500 Claim Form)

Procedure Code	Description	Certified Providers Who May Perform Service	Modifier (Required)	Limitations	Allowable ICD-9-CM[a] Diagnoses	Allowable Place of Service	Telehealth Services Covered?
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report	Neurologist, psychiatrist	UA	Six units of any combination of these procedure codes for each DOS.	All	11, 12, 21[b], 22, 23, 31, 32, 51[b], 54, 61[b]	No
		Doctoral level	HP				
96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face	Neurologist, psychiatrist	UA	Six units of any combination of these procedure codes for each DOS.	All	11, 12, 21[b], 22, 23, 31, 32, 51[b], 54, 61[b]	No
		Doctoral level	HP				
96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report	Neurologist, psychiatrist	UA	Six units of any combination of these procedure codes for each DOS.	All	11, 12, 21[b], 22, 23, 31, 32, 51[b], 54, 61[b]	No
		Doctoral level	HP				
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	Neurologist, psychiatrist	UA	Six units of any combination of these procedure codes for each DOS.	All	11, 12, 21[b], 22, 23, 31, 32, 51[b], 54, 61[b]	No
		Doctoral level	HP				
96110	Developmental testing; limited (eg, Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report	Neurologist, pediatrician, psychiatrist	UA	Six units of any combination of these procedure codes for each DOS.	All	11, 12, 21[b], 22, 23, 31, 32, 51[b], 54, 61[b]	No
		Doctoral level	HP				
96111	extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report	Neurologist, pediatrician, psychiatrist	UA	Six units of any combination of these procedure codes for each DOS.	All	11, 12, 21[b], 22, 23, 31, 32, 51[b], 54, 61[b]	No
		Doctoral level	HP				

[a] ICD-9-CM = *International Classification of Diseases, Ninth Revision, Clinical Modification*

[b] The POS codes "21," "51," and "61" are not allowable for Master's level providers. Payment is included in the hospital's Medicaid DRG reimbursement.

Procedure Code	Description	Certified Providers Who May Perform Service	Modifier (Required)	Limitations	Allowable ICD-9-CM[a] Diagnoses	Allowable Place of Service	Telehealth Services Covered?
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report	Neurologist, pediatrician, psychiatrist	UA	Six units of any combination of these procedure codes for each DOS.	All	11, 12, 21[b], 22, 23, 31, 32, 51[b], 54, 61[b]	No
		Doctoral level	HP				
96118	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report	Neurologist, psychiatrist	UA	Six units of any combination of these procedure codes for each DOS.	All	11, 12, 21[b], 22, 23, 31, 32, 51[b], 54, 61[b]	No
		Doctoral level	HP				
96119	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face	Neurologist, psychiatrist	UA	Six units of any combination of these procedure codes for each DOS.	All	11, 12, 21[b], 22, 23, 31, 32, 51[b], 54, 61[b]	No
		Doctoral level	HP				
96120	Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report	Neurologist, psychiatrist	UA	Six units of any combination of these procedure codes for each DOS.	All	11, 12, 21[b], 22, 23, 31, 32, 51[b], 54, 61[b]	No
		Doctoral level	HP				

[a] ICD-9-CM = *International Classification of Diseases, Ninth Revision, Clinical Modification*

[b] The POS codes "21," "51," and "61" are not allowable for Master's level providers. Payment is included in the hospital's Medicaid DRG reimbursement.

Health and Behavior Assessment Procedure Codes

(Submitted Only on the CMS 1500 Claim Form)

Procedure Code	Description	Certified Providers Who May Perform Service	Modifier (Required)	Limitations	Allowable ICD-9-CM[a] Diagnoses	Allowable Place of Service	Telehealth Services Covered?
96150	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment	Master's degree level	HO	Do not claim CPT 90801-90899 by same provider on the same DOS as 96150-96155. Up to eight units combined for 96150-96155 per DOS.	All except 290.0-298.9, 300.00-316.	03, 11, 21[b], 22, 23, 31, 32, 51[b], 54, 61[b]	Yes (use "GT" modifier)
		Doctoral level	HP				
		Psychiatrist	UA				
96151	re-assessment	Master's degree level	HO	Do not claim CPT 90801-90899 by same provider on the same DOS as 96150-96155. Up to eight units combined for 96150-96155 per DOS.	All except 290.0-298.9, 300.00-316.	03, 11, 21[b], 22, 23, 31, 32, 51[b], 54, 61[b]	Yes (use "GT" modifier)
		Doctoral level	HP				
		Psychiatrist	UA				

Health and Behavior Intervention Procedure Codes

(Submitted Only on the CMS 1500 Claim Form)

Procedure Code	Description	Certified Providers Who May Perform Service	Modifier (Required)	Limitations	Allowable ICD-9-CM* Diagnoses	Allowable Place of Service	Telehealth Services Covered?
96152	Health and behavior intervention, each 15 minutes, face-to-face; individual	Master's degree level	HO	Do not claim CPT 90801-90899 by same provider on the same DOS as 96150-96155. Accumulates toward a 15-hour/$500 calendar-year threshold of 96152-96155, beyond which PA is required. Up to eight units combined for 96150-96155 per DOS.	All except 290.0-298.9, 300.00-316.	03, 11, 21[b], 22, 23, 31, 32, 51[b], 54, 61[b]	Yes (use "GT" modifier)
		Doctoral level	HP				
		Psychiatrist	UA				
96153	group (2 or more patients)	Master's degree level	HO	Do not claim CPT 90801-90899 by same provider on the same DOS as 96150-96155. Accumulates toward a 15-hour/$500 calendar-year threshold of 96152-96155, beyond which PA is required. Up to eight units combined for 96150-96155 per DOS.	All except 290.0-298.9, 300.00-316.	03, 11, 21[b], 22, 23, 31, 32, 51[b], 54, 61[b]	No
		Doctoral level	HP				
		Psychiatrist	UA				
96154	family (with the patient present)	Master's degree level	HO	Do not claim CPT 90801-90899 by same provider on the same DOS as 96150-96155. Accumulates toward a 15-hour/$500 calendar-year threshold of 96152-96155, beyond which PA is required. Up to eight units combined for 96150-96155 per DOS.	All except 290.0-298.9, 300.00-316.	03, 11, 21**, 03, 11, 21[b], 22, 23, 31, 32, 51[b], 54, 61[b]	Yes (use "GT" modifier)
		Doctoral level	HP				
		Psychiatrist	UA				
96155	family (without the patient present)	Master's degree level	HO	Do not claim CPT 90801-90899 by same provider on the same DOS as 96150-96155. Accumulates toward a 15-hour/$500 calendar-year threshold of 96152-96155, beyond which PA is required. Up to eight units combined for 96150-96155 per DOS.	All except 290.0-298.9, 300.00-316.	03, 11, 21[b], 22, 23, 31, 32, 51[b], 54, 61[b]	Yes (use "GT" modifier)
		Doctoral level	HP				
		Psychiatrist	UA				

[a] ICD-9-CM = *International Classification of Diseases, Ninth Revision, Clinical Modification*

[b] The POS codes "21," "51," and "61" are not allowable for Master's level providers. Payment is included in the hospital's Medicaid DRG reimbursement.

ATTACHMENT 17
Outpatient Mental Health Services Maximum Allowable Fees and Copayment Rates

The following tables include maximum allowable fees and copayment rates for allowable *Current Procedural Terminology* and Healthcare Common Procedure Coding System codes. Maximum allowable fees for revenue codes are based on the hospital's outpatient encounter rate. Maximum allowable fees listed in this Attachment are the proposed fees effective July 1, 2002, and may be subject to change. Wisconsin Medicaid will notify providers if the fees change from those printed in this *Wisconsin Medicaid and BadgerCare Update.*

Professional Level Modifiers		
Modifier	**Description**	**Providers**
HO	Masters degree level	Master's-level psychotherapist — Master's-level psychotherapists are Master's-level mental health professionals with 3,000 hours of supervised experience or are listed in an appropriate national registry as stated in HFS 61.96, Wis. Admin. Code. This includes registered nurses (RNs) with a Master's degree in psychiatric-mental health nursing or community mental health nursing from a graduate school of nursing accredited by the National League for Nursing.
HP	Doctoral level	Psychologist, Ph.D.
UA	MD, neurologist, pediatrician, psychiatrist	Psychiatrist billing mental health and substance abuse services Physician billing substance abuse services Physician assistant billing substance abuse services
UB	APNP — psychiatric specialty	Advanced Practice Nurse Prescriber (APNP) — Master's-level RN, only those with an APNP — psychiatric specialty billing pharmacologic management
U8	Physician assistant	Physician assistant billing pharmacologic management

Outpatient Mental Health Services Procedure Codes

Psychiatric Diagnostic or Evaluative Interview Procedures

Procedure Code	Description	Certified Providers Who May Perform Service	Modifier (Required)	Maximum Allowable Fee Effective July 1, 2002	Copayment
90801	Psychiatric diagnostic interview examination (quantity of 1.0 = 1 hour)	Master's degree level	HO	$55.00	$3.00
		Doctoral level	HP	$65.00	$3.00
		Psychiatrist	UA	$80.13	$3.00
90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication (quantity of 1.0 = 1 hour)	Master's degree level	HO	$55.00	$3.00
		Doctoral level	HP	$65.00	$3.00
		Psychiatrist	UA	$80.13	$3.00
H0046	Mental health services, not otherwise specified (Wisconsin Medicaid: Limitation — Exceeded; Psychotherapy diagnostic interview examination [quantity of 1.0 = 1 hour])	Master's degree level	HO	$55.00	$3.00
		Doctoral level	HP	$65.00	$3.00
		Psychiatrist	UA	$80.13	$3.00

Psychiatric Therapeutic Procedures: Office or Other Outpatient Facility — *Insight Oriented, Behavior Modifying, and/or Supportive Psychotherapy*

Wisconsin Medicaid covers "partial hospital" services under a separate benefit — day treatment/day hospital services (HFS 107.13[4], Wis. Admin. Code).

Procedure Code	Description	Certified Providers Who May Perform Service	Modifier (Required)	Maximum Allowable Fee Effective July 1, 2002	Copayment
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;	Master's degree level	HO	$27.50	$2.00
		Doctoral level	HP	$32.50	$2.00
		Psychiatrist	UA	$40.06	$2.00
90805	with medical evaluation and management services	Psychiatrist	UA	$40.06	$2.00
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;	Master's degree level	HO	$55.00	$3.00
		Doctoral level	HP	$65.00	$3.00
		Psychiatrist	UA	$80.13	$3.00
90807	with medical evaluation and management services	Psychiatrist	UA	$80.13	$3.00
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;	Master's degree level	HO	$82.50	$3.00
		Doctoral level	HP	$97.50	$3.00
		Psychiatrist	UA	$120.19	$3.00
90809	with medical evaluation and management services	Psychiatrist	UA	$120.19	$3.00

Psychiatric Therapeutic Procedures: Office or Other Outpatient Facility — *Interactive Psychotherapy*

90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;	Master's degree level	HO	$27.50	$2.00
		Doctoral level	HP	$32.50	$2.00
		Psychiatrist	UA	$40.06	$2.00
90811	with medical evaluation and management services	Psychiatrist	UA	$40.06	$2.00
90812	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;	Master's degree level	HO	$55.00	$3.00
		Doctoral level	HP	$65.00	$3.00
		Psychiatrist	UA	$80.13	$3.00
90813	with medical evaluation and management services	Psychiatrist	UA	$80.13	$3.00
90814	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;	Master's degree level	HO	$82.50	$3.00
		Doctoral level	HP	$97.50	$3.00
		Psychiatrist	UA	$120.19	$3.00
90815	with medical evaluation and management services	Psychiatrist	UA	$120.19	$3.00
90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;	Master's degree level	HO	$27.50	$2.00
		Doctoral level	HP	$32.50	$2.00
		Psychiatrist	UA	$40.06	$2.00
90817	with medical evaluation and management services	Psychiatrist	UA	$40.06	$2.00
90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;	Master's degree level	HO	$55.00	$3.00
		Doctoral level	HP	$65.00	$3.00
		Psychiatrist	UA	$80.13	$3.00
90819	with medical evaluation and management services	Psychiatrist	UA	$80.13	$3.00
90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;	Master's degree level	HO	$82.50	$3.00
		Doctoral level	HP	$97.50	$3.00
		Psychiatrist	UA	$120.19	$3.00
90822	with medical evaluation and management services	Psychiatrist	UA	$120.19	$3.00

Psychiatric Therapeutic Procedures: Inpatient Hospital or Residential Care Facility — *Interactive Psychotherapy*

See HFS 107.13, Wis. Admin. Code, for the Medicaid policy on partial hospital/day treatment services. Wisconsin Medicaid covers "partial hospital" services under a separate benefit — day treatment/day hospital services.

Procedure Code	Description	Certified providers Who May Perform Service	Modifier (Required)	Maximum Allowable Fee Effective July 1, 2002	Copayment
90823	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;	Master's degree level	HO	$27.50	$2.00
		Doctoral level	HP	$32.50	$2.00
		Psychiatrist	UA	$40.06	$2.00
90824	with medical evaluation and management services	Psychiatrist	UA	$40.06	$2.00
90826	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;	Master's degree level	HO	$55.00	$3.00
		Doctoral level	HP	$65.00	$3.00
		Psychiatrist	UA	$80.13	$3.00
90827	with medical evaluation and management services	Psychiatrist	UA	$80.13	$3.00
90828	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;	Master's degree level	HO	$82.50	$3.00
		Doctoral level	HP	$97.50	$3.00
		Psychiatrist	UA	$120.19	$3.00
90829	with medical evaluation and management services	Psychiatrist	UA	$120.19	$3.00

Psychiatric Therapeutic Procedures: Other Psychotherapy

90845	Psychoanalysis (quantity of 1.0 = 60 minutes)	Master's degree level	HO	$55.00	$3.00
		Doctoral level	HP	$65.00	$3.00
		Psychiatrist	UA	$80.13	$3.00
90846	Family psychotherapy (without the patient present) (quantity of 1.0 = 60 minutes)	Master's degree level	HO	$55.00	$3.00
		Doctoral level	HP	$65.00	$3.00
		Psychiatrist	UA	$80.13	$3.00
90847	Family psychotherapy (conjoint psychotherapy) (with patient present) (quantity of 1.0 = 60 minutes)	Master's degree level	HO	$55.00	$3.00
		Doctoral level	HP	$65.00	$3.00
		Psychiatrist	UA	$80.13	$3.00
90849	Multiple-family group psychotherapy (quantity of 1.0 = 60 minutes)	Master's degree level	HO	$61.41	$3.00
		Doctoral level	HP	$72.30	$3.00
		Psychiatrist	UA	$90.16	$3.00
90853	Group psychotherapy (other than of a multiple-family group) (quantity of 1.0 = 60 minutes)	Master's degree level	HO	$11.26	$1.00
		Doctoral level	HP	$13.82	$1.00
		Psychiatrist	UA	$20.23	$1.00
90857	Interactive group psychotherapy (quantity of 1.0 = 60 minutes)	Master's degree level	HO	$11.26	$1.00
		Doctoral level	HP	$13.82	$1.00
		Psychiatrist	UA	$20.23	$1.00

Psychiatric Therapeutic Procedures: Other Psychiatric Services or Procedures

Procedure Code	Description	Certified Providers Who May Perform Service	Modifier (Required)	Maximum Allowable Fee Effective July 1, 2002	Copayment
90862	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy (quantity of 1.0 = 15 minutes)	Master's level psychiatric nurse	HO	$15.75	
		APNP — psychiatric	UB	$31.68	
		Physician Assistant	U8	$28.51	
		MD, Psychiatrist	UA	$31.68	
90865	Narcosynthesis for psychiatric diagnostic and therapeutic purposes (eg, sodium amobarbital [Amytal] interview) (quantity of 1.0 = 60 minutes)	Doctoral level	HP	$65.00	$3.00
		Psychiatrist	UA	$80.13	$3.00
90870	Electroconvulsive therapy (includes necessary monitoring)	Psychiatrist	UA	$132.80	$3.00
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes	Master's degree level	HO	$27.50	$2.00
		Doctoral level	HP	$32.50	$2.00
		Psychiatrist	UA	$40.06	$2.00
90876	approximately 45-50 minutes	Master's degree level	HO	$55.00	$3.00
		Doctoral level	HP	$65.00	$3.00
		Psychiatrist	UA	$80.13	$3.00
90880	Hypnotherapy (quantity of 1.0 = 60 minutes)	Master's degree level	HO	$55.00	$3.00
		Doctoral level	HP	$65.00	$3.00
		Psychiatrist	UA	$80.13	$3.00
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient (quantity of 1.0 = 60 minutes)	Master's degree level	HO	$55.00	$3.00
		Doctoral level	HP	$65.00	$3.00
		Psychiatrist	UA	$80.13	$3.00
90899[a, b]	Unlisted psychiatric service or procedure (quantity of 1.0 = 60 minutes)	Master's degree level	HO	Individually Considered	$3.00
		Doctoral level	HP	Individually Considered	$3.00
		Psychiatrist	UA	Individually Considered	$3.00

[a] This code is to be used by all providers only when greater than 90 minutes of individual psychotherapy is provided on one day. Bill the total time (quantity of 1.0 = 60 minutes). It is not to be used for group psychotherapy. Submit with documentation showing medical necessity.

[b] Not payable in conjunction with 90804-90819, 90821-90824, 90826-90829, 90845, or 90875-90876 by the same provider on the same date of service.

Outpatient Mental Health Services Revenue Codes

Revenue Code	Category	Description	Certified Providers Who May Perform Service	Modifier (Required)	Rate	Copayment
0900	Psychiatric/ Psychological Treatments	General Classification	Master's degree level	HO	The hospital's specific rate per visit.	$3.00 per visit, per day
			Doctoral level	HP		
			Psychiatrist	UA		
0902	Psychiatric/ Psychological Treatments	Milieu Therapy	Master's degree level	HO	The hospital's specific rate per visit.	$3.00 per visit, per day
			Doctoral level	HP		
			Psychiatrist	UA		
0903	Psychiatric/ Psychological Treatments	Play Therapy	Master's degree level	HO	The hospital's specific rate per visit.	$3.00 per visit, per day
			Doctoral level	HP		
			Psychiatrist	UA		
0909	Psychiatric/ Psychological Treatments	Other Psychiatric/ Psychological Treatment	Master's degree level	HO	The hospital's specific rate per visit.	$3.00 per visit, per day
			Doctoral level	HP		
			Psychiatrist	UA		
0910	Psychiatric/ Psychological Treatments	General Classification	Master's degree level	HO	The hospital's specific rate per visit.	$3.00 per visit, per day
			Doctoral level	HP		
			Psychiatrist	UA		
0911	Psychiatric/ Psychological Treatments	Rehabilitation	Master's degree level	HO	The hospital's specific rate per visit.	$3.00 per visit, per day
			Doctoral level	HP		
			Psychiatrist	UA		
0914	Psychiatric/ Psychological Treatments	Individual Therapy	Master's degree level	HO	The hospital's specific rate per visit.	$3.00 per visit, per day
			Doctoral level	HP		
			Psychiatrist	UA		
0915	Psychiatric/ Psychological Treatments	Group Therapy	Master's degree level	HO	The hospital's specific rate per visit.	$3.00 per visit, per day
			Doctoral level	HP		
			Psychiatrist	UA		
0916	Psychiatric/ Psychological Treatments	Family Therapy	Master's degree level	HO	The hospital's specific rate per visit.	$3.00 per visit, per day
			Doctoral level	HP		
			Psychiatrist	UA		
0919	Psychiatric/ Psychological Treatments	Other Psychiatric/ Psychological Service	Master's degree level	HO	The hospital's specific rate per visit.	$3.00 per visit, per day
			Doctoral level	HP		
			Psychiatrist	UA		

Central Nervous System Assessments/Tests Procedure Codes

Procedure Code	Description	Certified Providers Who May Perform Service	Modifier (Required)	Maximum Allowable Fee Effective January 1, 2006	Copayment
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report	Neurologist, pediatrician, psychiatrist	UA	$80.13	$3.00
		Doctoral level	HP	$65.00	
96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face	Neurologist, pediatrician, psychiatrist	UA	$72.12	$3.00
		Doctoral level	HP	$58.50	
96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report	Neurologist, pediatrician, psychiatrist	UA	$72.12	$3.00
		Doctoral level	HP	$58.50	
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	Neurologist, psychiatrist	UA	$80.13	$2.00
		Doctoral level	HP	$65.00	
96110	Developmental testing; limited (eg, Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report	Neurologist, psychiatrist	UA	$80.13	$3.00
		Doctoral level	HP	$65.00	
96111	extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report	Neurologist, pediatrician, psychiatrist	UA	$80.13	$3.00
		Doctoral level	HP	$65.00	
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report	Neurologist, pediatrician, psychiatrist	UA	$80.13	$3.00
		Doctoral level	HP	$65.00	
96118	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report	Neurologist, psychiatrist	UA	$80.13	$3.00
		Doctoral level	HP	$65.00	
96119	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face	Neurologist, psychiatrist	UA	$72.12	$3.00
		Doctoral level	HP	$58.50	
96120	Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report	Neurologist, psychiatrist	UA	$72.12	$3.00
		Doctoral level	HP	$58.50	

Health and Behavior Assessment Procedure Codes

Procedure Code	Description	Certified Providers Who May Perform Service	Modifier (Required)	Maximum Allowable Fee Effective October 1, 2005	Copayment
96150	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment	Master's degree level	HO	$13.75	$1.00
		Doctoral level	HP	$16.25	
		Psychiatrist	UA	$20.03	
96151	re-assessment	Master's degree level	HO	$13.75	$1.00
		Doctoral level	HP	$16.25	
		Psychiatrist	UA	$20.03	

Health and Behavior Intervention Procedure Codes

Procedure Code	Description	Certified Providers Who May Perform Service	Modifier (Required)	Maximum Allowable Fee Effective October 1, 2005	Copayment
96152	Health and behavior intervention, each 15 minutes, face-to-face; individual	Master's degree level	HO	$13.75	$1.00
		Doctoral level	HP	$16.25	
		Psychiatrist	UA	$20.03	
96153	group (2 or more patients)	Master's degree level	HO	$2.82	$.50
		Doctoral level	HP	$3.46	
		Psychiatrist	UA	$5.06	
96154	family (with the patient present)	Master's degree level	HO	$13.75	$1.00
		Doctoral level	HP	$16.25	
		Psychiatrist	UA	$20.03	
96155	family (without the patient present)	Master's degree level	HO	$13.75	$1.00
		Doctoral level	HP	$16.25	
		Psychiatrist	UA	$20.03	

ATTACHMENT 18
Rounding Guidelines for Outpatient Mental Health Services

The following table illustrates the rules of rounding and gives the appropriate billing unit for all services *except* pharmacologic management and electroconvulsive therapy.* Providers should use these rounding guidelines only when 1.0 unit of service is equal to one hour. Providers should follow the time specified in the procedure code description for all other codes.

Outpatient Mental Health Services	
Time (Minutes)	**Unit(s) Billed**
1-6	.1
7-12	.2
13-18	.3
19-24	.4
25-30	.5
31-36	.6
37-42	.7
43-48	.8
49-54	.9
55-60	1.0

*Electroconvulsive therapy reimbursement is made on a daily basis; therefore, there are no rounding guidelines for this service.

The following table illustrates the rules of rounding and gives the appropriate billing unit for pharmacologic management. Providers should use these rounding guidelines only when 1.0 unit of service is equal to 15 minutes. Providers should follow the time specified in the procedure code description for all other codes.

Pharmacologic Management Rounding Guidelines	
Time (Minutes)	**Unit(s) Billed**
1-3	.2
4-6	.4
7-9	.6
10-12	.8
13-15	1.0
16-18	1.2
19-21	1.4
22-24	1.6
25-27	1.8
28-30	2.0

ATTACHMENT 19
CMS 1500 Claim Form Instructions for Outpatient Mental Health Services

Use the following claim form completion instructions, *not* the claim form's printed descriptions, to avoid denial or inaccurate Medicaid claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Medicaid Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Informational Resources section of the All-Provider Handbook or the Medicaid Web site for more information about the EVS.

Submit completed paper claims to the following address:

Wisconsin Medicaid
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

Element 1 — Program Block/Claim Sort Indicator

County-owned outpatient mental health services clinics
Enter claim sort indicator "M" in the Medicaid check box for the service billed.

Psychiatrists and Ph.D. psychologists in private practice and privately owned outpatient mental health services clinics (by Master's-level providers, physicians, and Ph.D. psychologists)
Enter claim sort indicator "P" in the Medicaid check box for the service billed.

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or the EVS to obtain the correct identification number.

Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Patient's Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the recipient is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence, if known.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name

Commercial health insurance must be billed prior to submitting claims to Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid.

If the EVS indicates that the recipient has dental ("DEN") insurance only or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), Medicare Supplement ("SUP"), TriCare ("CHA"), Vision only ("VIS"), a health maintenance organization ("HMO"), or some other ("OTH") commercial health insurance, *and* the service requires other insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes *must* be indicated in the *first* box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: ✓ The recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ The recipient's commercial health insurance failed to respond to initial and follow-up claims. ✓ Benefits are not assignable or cannot get assignment. ✓ Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the recipient is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill Wisconsin Medicaid for services that are included in the capitation payment.

Element 10 — Is Patient's Condition Related to (not required)

Element 11 — Insured's Policy, Group, or FECA Number

Use the *first* box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Submit claims to Medicare before submitting claims to Wisconsin Medicaid.

Outpatient mental health services providers are *not* required to be Medicare enrolled to provide Medicare-covered services for dual eligibles. Dual eligibles are those recipients covered under both Medicare and Wisconsin Medicaid.

Element 11 should be left blank when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does not have any Medicare coverage, including Medicare Cost ("MCC") or Medicare + Choice ("MPC"), for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.
- Wisconsin Medicaid indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate.

Code	Description
M-5	**Provider is not Medicare certified.** This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for dates of service (DOS) before or after their Medicare certification effective dates. Use M-5 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part A. ✓ The procedure provided is covered by Medicare Part A. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part B. ✓ The procedure provided is covered by Medicare Part B.
M-7	**Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.
M-8	**Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is usually covered by Medicare Part A but not in this circumstance (e.g., recipient's diagnosis). *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is usually covered by Medicare Part B but not in this circumstance (e.g., recipient's diagnosis).

Elements 12 and 13 — Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source

For outpatient mental health services, the prescribing physician's name and Universal Provider Identification Number, eight-digit Medicaid provider number, or license number is required for all services *except* evaluation (90801 and 90802) and mental health services/substance abuse services, not otherwise specified (H0046). If a psychiatrist is the referring or prescribing provider *and* the performing provider, the psychiatrist's name and provider number must be entered in this element.

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use

If a provider bills an unlisted (or not otherwise specified) procedure code (90899 [Unlisted psychiatric service or procedure]), a description of the procedure must be indicated in this element. If Element 19 does not provide enough space for the procedure description, or if a provider is billing multiple unlisted procedure codes, documentation must be attached to the claim describing the procedure(s). In this instance, indicate "See Attachment" in Element 19.

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required. Refer to Attachment 16 of this *Wisconsin Medicaid and BadgerCare Update* for allowable diagnosis codes.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Request Form (PA/RF, HCF 11018). Services authorized under multiple PA requests must be billed on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim.

Element 24A — Date(s) of Service

Enter the month, day, and year for each service using the following guidelines:

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field and enter subsequent DOS in the "To" field by listing *only* the date(s) of the month. For example, for DOS January 12 through 15, 2006, enter 01/12/06 or 01/12/2006 in the "From" field and enter 13/14/15 in the "To" field.

It is allowable to enter up to four DOS per line if the following are true:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All services have the same place of service (POS) code.
- All services were performed by the same provider.
- The same diagnosis is applicable for each service.
- The charge for all services is identical. (Enter the total charge *per detail line* in Element 24F.)
- The number of services performed on each DOS is identical.
- All services have the same family planning indicator, if applicable.
- All services have the same emergency indicator, if applicable.

Element 24B — Place of Service

Enter the appropriate two-digit POS code for each service. Refer to Attachment 16 for allowable POS codes for outpatient mental health and substance abuse services.

Notes: Services provided to a hospital inpatient recipient by Master's-level psychotherapists or substance abuse counselors are not separately reimbursable as mental health professional services.

Group therapy and medication management services are not separately reimbursable by any provider as professional mental health services when provided to a hospital inpatient recipient.

Element 24C — Type of Service (not required)

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code. Wisconsin Medicaid denies claims received without an appropriate procedure code.

Modifiers

Enter the appropriate modifier in the "Modifier" column of Element 24D.

Note: Wisconsin Medicaid has not adopted all modifiers.

Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate ICD-9-CM diagnosis code listed in Element 21.

Element 24F — $ Charges

Enter the total charge for each line item. Providers are required to bill Wisconsin Medicaid their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Medicaid benefits.

Element 24G — Days or Units

Enter the appropriate number of units for each line item. Always use a decimal (e.g., 2.0 units). Refer to Attachment 18 for rounding guidelines.

Element 24H — EPSDT/Family Plan (not required)

Element 24I — EMG (not required)

Element 24J — COB (not required)

Element 24K — Reserved for Local Use

Enter the eight-digit Medicaid provider number of the performing provider for each procedure. When submitting claims for pharmacologic management (90862 [Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy]; i.e., medication check) performed by a registered nurse other than a Master's-level psychiatric nurse, enter the eight-digit Medicaid provider number of the supervising physician if the Master's-level psychiatric nurse is *not* individually Medicaid certified. Enter the Medicaid provider number of the Master's-level psychiatric nurse if the nurse *is* separately Medicaid certified.

When the billing provider is a "biller only" provider, indicate the performing provider's individual Medicaid provider number.

Any other information entered in this element may cause claim denial.

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No. (not required)

Optional — Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice transaction.

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Element 29 is greater than zero, "OI-P" must be indicated in Element 9.) If the commercial health insurance denied the claim, enter "000." Do *not* enter Medicare-paid amounts in this field.

Element 30 — Balance Due

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

Element 31 — Signature of Physician or Supplier

The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 — Name and Address of Facility Where Services Were Rendered (not required)

If the services were provided to a recipient in a nursing facility (POS code "31," "32," or "54"), indicate the nursing home's Medicaid provider number.

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, street, city, state, and ZIP code. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

ATTACHMENT 20

Sample CMS 1500 Claim Form for Outpatient Mental Health Services in a County-Owned Clinic

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) — **M**

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): **1234567890**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Recipient, Im A.**

3. PATIENT'S BIRTH DATE MM DD YY: **MM DD YY** SEX M ☐ F **X**

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): **609 Willow St**

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: **Anytown** STATE: **WI**

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: **55555** TELEPHONE (Include Area Code): **(XXX) XXX-XXXX**

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): **OI-P**

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: **M-7**

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: **I.M. Referring/Prescribing**

17a. I.D. NUMBER OF REFERRING PHYSICIAN: **12345678**

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. **296.35** 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 08 06		11		90845	HP	1	XXX XX	2.0				
2 01 15 06		11		90847	HO	1	XX XX	1.0				
3 01 22 06		11		90862	U8	1	XX XX	1.0				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: **1234JED**

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE: $ XXX XX

29. AMOUNT PAID: $ XX XX

30. BALANCE DUE: $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Provider MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 **87654321**

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

ATTACHMENT 21
Sample CMS 1500 Claim Form for Outpatient Mental Health Services in a Private Clinic

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) P | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY | SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow St

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-7

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring/Prescribing

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 12345678

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 296.35
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 08 06		11		90845	HP	1	XXX XX	2.0				11223344
2 01 15 06		11		90847	HO	1	XX XX	1.0				11223355
3 01 22 06		11		90862	U8	1	XX XX	1.0				44332211
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ XXX XX

29. AMOUNT PAID: $ XX XX

30. BALANCE DUE: $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Provider MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 76543210

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

ATTACHMENT 22

Sample CMS 1500 Claim Form for Billing-Only Agencies

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow St

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-7

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring/Prescribing

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 12345678

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 296.35 3. ____ 2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 08 06		11		90845	HP	1	XXX XX	2.0				65432109
2 01 15 06		11		90847	HO	1	XX XX	1.0				
3 01 22 06		11		90862	U8	1	XX XX	1.0				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $ XX XX

30. BALANCE DUE $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Provider MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

ATTACHMENT 23
UB-92 (CMS 1450) Claim Form Instructions for Outpatient Mental Health Services

Use the following claim form completion instructions, **not** the form locator descriptions printed on the claim form, to avoid denied claims or inaccurate claim payment. Complete all required form locators as appropriate. Do not include attachments unless instructed to do so.

These instructions are for the completion of the UB-92 (CMS 1450) claim for Wisconsin Medicaid. For complete billing instructions, refer to the National UB-92 Uniform Billing Manual prepared by the National Uniform Billing Committee (NUBC). The National UB-92 Uniform Billing Manual contains important coding information not available in these instructions. Providers may purchase the National UB-92 Uniform Billing Manual by calling (312) 422-3390 or writing to the following address:

American Hospital Association
National Uniform Billing Committee
29th Fl
1 N Franklin
Chicago IL 60606

For more information, go to the NUBC Web site at *www.nubc.org/*.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Medicaid Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Informational Resources section of the All-Provider Handbook or the Medicaid Web site for more information about the EVS.

Submit completed paper claims to the following address:

Wisconsin Medicaid
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

Form Locator 1 — Provider Name, Address, and Telephone Number

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, city, state, and ZIP code. The name in Form Locator 1 should correspond with the provider number in Form Locator 51.

Form Locator 2 — ERO Assigned Number (required, if applicable)

Enter the Pre-Admission Review control number as required.

Form Locator 3 — Patient Control No. (not required)

Form Locator 4 — Type of Bill

Enter the three-digit type of bill number. The first digit identifies the type of facility. The second digit classifies the type of care. The third digit ("X") indicates the billing frequency and providers should enter one of the following for "X":

1 = Admit through discharge claim.
2 = Interim — first claim.
3 = Interim — continuing claim.
4 = Interim — final claim.

Form Locator 5 — Fed. Tax No. (not required)

Form Locator 6 — Statement Covers Period (From - Through)

Enter both dates in MM/DD/YY format (e.g., January 2, 2006, would be 010206).

Form Locator 7 — Cov D.

Enter the total number of days covered by the primary payer. For outpatient claims, covered days must represent the actual number of visits (days of service) in the "from - through" period.

Form Locator 8 — N-C D.

Enter the total noncovered days by the primary payer. The sum of covered days and noncovered days must equal the number of days in the "from - through" period.

Form Locator 9 — C-I D. (not required)

Form Locator 10 — L-R D. (not required)

Form Locator 11 — Unlabeled Field (not required)

Form Locator 12 — Patient Name

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Form Locator 13 — Patient Address (not required)

Form Locator 14 — Birthdate (not required)

Form Locator 15 — Sex (not required)

Form Locator 16 — MS (not required)

Form Locator 17 — Admission Date (not required)

Form Locator 18 — Admission Hr (not required)

Form Locator 19 — Admission Type (not required)

Form Locator 20 — Admission Src

Enter the code indicating the source of this admission.

Form Locator 21 — D Hr (not required)

Form Locator 22 — Stat (not required)

Form Locator 23 — Medical Record No. (not required)

Form Locators 24-30 — Condition Codes (required, if applicable)

Form Locator 31 — Unlabeled Field (not required)

Form Locators 32-35 a-b — Occurrence Code and Date (required, if applicable)

Form Locator 36 a-b — Occurrence Span Code (From - Through) (not required)

Form Locator 37 A-C — Internal Control Number/Document Control Number (not required)

Form Locator 38 — Responsible Party Name and Address (not required)

Form Locators 39-41 a-d — Value Code and Amount (required, if applicable)

Wisconsin Medicaid uses the following value codes.

Code	Description
81	*Medicare Part B Charges When Part A Exhausted*. Enter the full amount of Medicare Part B charges when billing for services after Medicare Part A has been exhausted.
83	*Medicare Part A Charges When Part A Exhausted*. Enter the sum of the Medicare paid amount, the coinsurance amount, and the deductible when billing for services after Medicare Part A has been exhausted.

Form Locator 42 — Rev. Cd.

Enter the national four-digit revenue code which identifies a specific accommodation, ancillary service, or billing calculation. Enter revenue code "0001" on the line with the sum of all the charges.

Form Locator 43 — Description (not required)

Form Locator 44 — HCPCS/Rates (not required)

Form Locator 45 — Serv. Date

Enter the DOS in MM/DD/YY format in Form Locator 45 or Form Locator 43. Multiple DOS must be indicated in Form Locator 43.

Form Locator 46 — Serv. Units

Enter the number of covered accommodations days, ancillary units of service, or visits, where appropriate.

Form Locator 47 — Total Charges

Enter the usual and customary charges pertaining to the related revenue code for the current billing period as entered in Form Locator 6, "statement covers period." Enter revenue code "0001" to report the sum of all charges in Form Locator 47.

Form Locator 48 — Non-covered Charges (not required)

Form Locator 49 — Unlabeled Field (not required)

Form Locator 50 A-C — Payer

Enter all health insurance payers here. For example, enter "T19" for Wisconsin Medicaid and/or the name of commercial health insurance.

Form Locator 51 A-C — Provider No.

Enter the number assigned to the provider by the payer indicated in Form Locator 50 A-C. For Wisconsin Medicaid, enter the eight-digit provider number. The provider number in Form Locator 51 should correspond with the name in Form Locator 1.

Form Locator 52 A-C — Rel Info (not required)

Form Locator 53 A-C — Asg Ben (not required)

Form Locator 54 A-C & P — Prior Payments (required, if applicable)

Enter the actual amount paid by commercial health insurance. (If the dollar amount indicated in Form Locator 54 is greater than zero, "OI-P" must be indicated in Form Locator 84.) If the commercial health insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

Form Locator 55 A-C & P — Est Amount Due (not required)

Form Locator 56 — Unlabeled Field (not required)

Form Locator 57 — Unlabeled Field (not required)

Form Locator 58 A-C — Insured's Name (not required)

Form Locator 59 A-C — P. Rel (not required)

Form Locator 60 A-C — Cert. - SSN - HIC. - ID No.

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or EVS to obtain the correct identification number.

Form Locator 61 A-C — Group Name (not required)

Form Locator 62 A-C — Insurance Group No. (not required)

Form Locator 63 A-C — Treatment Authorization Codes (required, if applicable)

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Request Form (PA/RF). Services authorized under multiple PA requests must be billed on separate claim forms with their respective PA numbers. Wisconsin Medicaid will accept one PA number per claim.

Form Locator 64 A-C — ESC (not required)

Form Locator 65 A-C — Employer Name (not required)

Form Locator 66 A-C — Employer Location (not required)

Form Locator 67 — Prin. Diag Cd.

Enter the complete *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) code describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible for causing the admission or other health care episode). Any condition which is not manifested upon admission or that develops subsequently should not be selected as the principal diagnosis.

Form Locators 68-75 — Other Diag. Codes

Enter the ICD-9-CM diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and that have an effect on the treatment received or the length of stay. Diagnoses which relate to an earlier episode and have no bearing on this episode are to be excluded. Providers should prioritize diagnosis codes as relevant to this claim.

Form Locator 76 — Adm. Diag. Cd. (not required)

Form Locator 77 — E-Code (not required)

Form Locator 78 — Race/Ethnicity (not required)

Form Locator 79 — P.C. (not required)

Form Locator 80 — Principal Procedure Code and Date (required, if applicable)

Enter the procedure code that identifies the principal procedure performed during the period covered by this claim and the date on which the principal procedure described on the claim was performed.

Note: Most often the principal procedure will be that procedure which is most closely related to the principal discharge diagnosis.

Form Locator 81 — Other Procedure Code and Date (required, if applicable)

If more than six procedures are performed, report those that are most important for the episode using the same guidelines in Form Locator 80 for determining the principal procedure.

Form Locator 82 a-b — Attending Phys. ID

Enter the Unique Physician Identification Number (UPIN) or license number and name.

Form Locator 83 a-b — Other Phys. ID

Enter the UPIN or license number and name.

Form Locator 84 a-d — Remarks (enter information when applicable)

Commercial health insurance billing information

Commercial health insurance coverage must be billed prior to billing Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid.

If the recipient has dental ("DEN"), Medicare Cost ("MCC"), Medicare + Choice ("MPC") insurance only, or has no commercial health insurance, do not indicate an other insurance (OI) explanation code in Form Locator 84.

When the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), Medicare Supplement ("SUP"), TriCare ("CHA"), Vision only ("VIS"), a health maintenance organization ("HMO"), or some other ("OTH") commercial insurance, ***and*** the service requires commercial health insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three OI explanation codes ***must*** be indicated in Form Locator 84. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Form Locator 54 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: ✓ The recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ The recipient's commercial health insurance failed to respond to initial and follow-up claims. ✓ Benefits are not assignable or cannot get assignment. ✓ Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the recipient is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not submit claims to Wisconsin Medicaid for services that are included in the capitation payment.

Medicare information

Use Form Locator 84 for Medicare information. Submit claims to Medicare before billing Wisconsin Medicaid.

Do not indicate a Medicare disclaimer code when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.
- Wisconsin Medicaid indicates the provider is not Medicare certified.

Note: Home health agencies, medical equipment vendors, pharmacies, and physician services providers are required to be Medicare certified to perform Medicare-covered services for dual eligibles.

- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits or Medicare Remittance Advice, but do not indicate on the claim form the amount Medicare paid.

If none of the previous Medicare information is true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate.

Code	Description
M-5	**Provider is not Medicare certified.** This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for DOS before or after their Medicare certification effective dates. Use M-5 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part A. ✓ The procedure provided is covered by Medicare Part A. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part B. ✓ The procedure provided is covered by Medicare Part B.
M-7	**Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted.
M-8	**Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances: *For Medicare Part A (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is usually covered by Medicare Part A but not in this circumstance (e.g., recipient's diagnosis). *For Medicare Part B (all three criteria must be met):* ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is usually covered by Medicare Part B but not in this circumstance (e.g., recipient's diagnosis).

Form Locator 85 — Provider Representative

The provider or the authorized representative must sign in Form Locator 85.

Note: The signature may be a computer-printed or typed name, or a signature stamp.

Form Locator 86 — Date

Enter the month, day, and year on which the claim is submitted to the payer. The date must be entered in MM/DD/YY or MM/DD/YYYY format.

ATTACHMENT 24

Sample UB-92 Claim Form for Outpatient Mental Health Services

APPROVED OMB NO. 0938-0279

IM BILLING HOSPITAL 321 HOSPITAL RD ANYTOWN, WI 55555 (555) 321-1234	2			3 PATIENT CONTROL NO.					4 TYPE OF BILL 131	
	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11		
		020406	020906	1						

12 PATIENT NAME	13 PATIENT ADDRESS
RECIPIENT, IMA H.	

14 BIRTHDATE	15 SEX	16 MS	17 DATE	ADMISSION 18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	CONDITION CODES 25	26	28	30	31
				3	1										

	32 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a								A
b								B
								C

38	39 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a			a
	b			b
	c			c
	d			d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0914			020506	1.0	46 00		1
2								2
3								3
4								4
5						46 00		5
6	001	Total						6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19	0001	Total Charges						19
20								20
21								21
22								22
23						XXXX XX		23

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56
A	45009 BLUE CROSS	BC111			XXXX XX		
B	T19 MEDICAID	87654321					
C						XX XX	
	57	DUE FROM PATIENT ▶					

	58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A			1234567890		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

67 PRIN. DIAG. CD.	68 CODE	OTHER DIAG. CODES 70 CODE	72 CODE	74 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
296.13							

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID	
						a
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE		b
					83 OTHER PHYS. ID N24680 I.M. Referring, M.D.	a
						b
					OTHER PHYS. ID	a
						b

	84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
a			
b			
c			
d		X *Ima H. Provider*	030104

UB-92 HCFA-1450 **OCR/Original**

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.